TRAINING OF PHC PERSONNEL IN MENTAL HEALTH CARE

NIMHANS' EXPERIENCES

1990

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
BANGALORE-560 029

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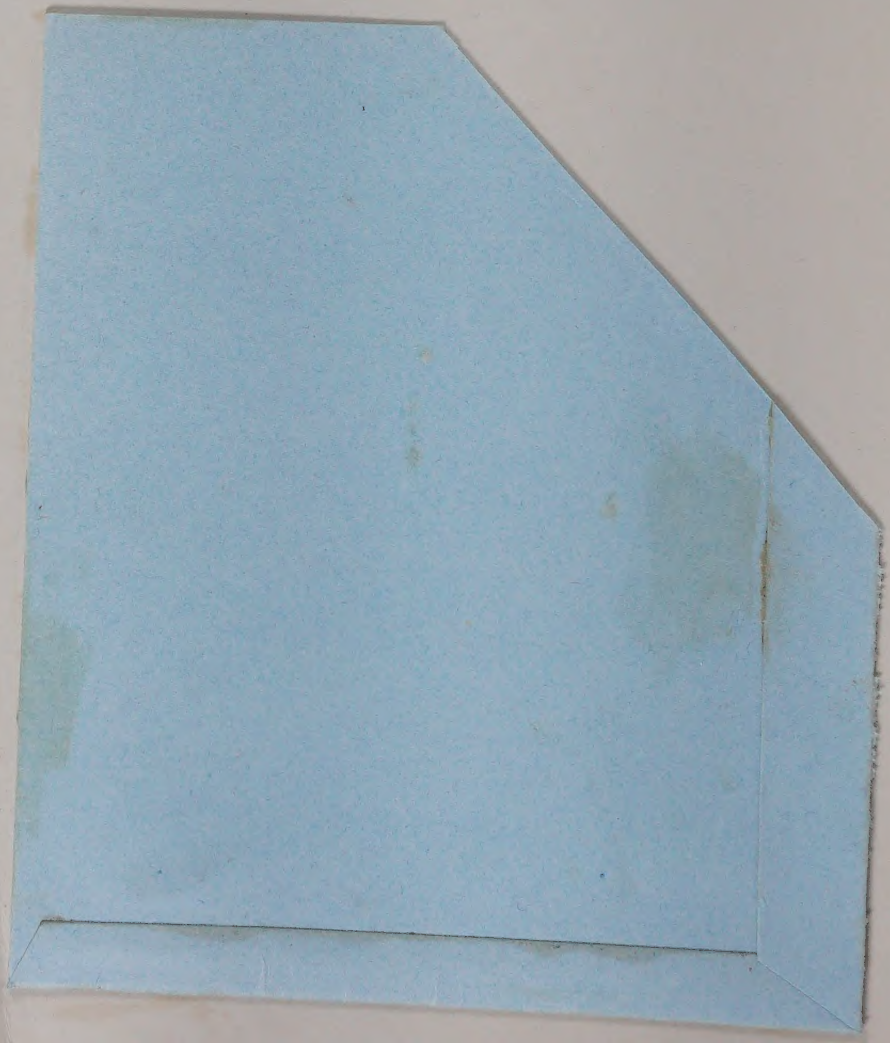

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FOREWORD

The National Mental Health Programme of India envisages delivery of mental health care through primary health care personnel. This requires short term, task oriented training courses for primary health care doctors and health workers. As part of community mental health activities, NIMHANS started pilot training programmes for PHC personnel in 1978 at Malur, Kolar District and in 1979 at Anekal, Bangalore district and later from 1982 centralized one or two weeks courses every month at Rural Mental Health Centre, Sakalawara. At the end of June 1990, NIMHANS has trained 728 doctors and 1238 health workers in mental health care. During this period, it was possible to evolve models of such training programmes for these PHC personnel which are being taken up by other Institutions in the country and abroad, where community based programmes are being organised by mental health professionals.

It was found out that the optimum periods for training health workers and doctors were 6 and 12 working days respectively which were readily accepted by the concerned health personnel. NIMHANS has also conducted training course of 4 weeks duration for trainers of PHC personnel of our country and of many other countries.

This book is an attempt to share NIMHANS' experiences in evolving such short term training courses in mental health care for PHC personnel which include syllabi and methodology of training. We hope that professionals in the area of health in general and mental health in particular will make use of these experiences in taking mental health care into the community.

S. M. CHANNABASAVANNA
Director

CONTENTS

CHAPTER 1

NATIONAL MENTAL HEALTH PROGRAMME (NMHP)-1982

India is a signatory State to the Alma Ata Declaration which envisages Health For All by the year 2000 as the goal and primary health care as an approach. Health has been defined not as merely absence of disease but as a state of positive well-being : physical mental and social. Mental health, therefore, forms an essential part of total health and as such must form an integral part of the national health policy.

Contrary to the popularly held belief, mental illness is widely prevalent in India and the prevalence is certainly not less than what is reported in the Western countries. Furthermore, the figures in India are as high in rural as in the urban areas. The Indian scientists have brought out enough evidence that at least 10-20 per thousand suffer from severe mental illness at any given time and at least three to five times that number suffer from other forms of distressing and socio-economically incapacitating emotional disorders. It has also been shown that 15-20% of the people who visit general health services such as a medical out-patient department or private practitioner or a primary health care centre have in fact emotional problems appearing as physical symptoms.

With the help of the Government of India and the WHO, a series of meetings were arranged with specialists in the field of mental health as well as experts in education, social welfare, law, labour and leaders engaged in various national developmental programmes. As a result of these meetings, a proposal for National Mental Health Programme (NMHP) for the country has been formulated. This programme has been designed keeping in view the magnitude of mental health problems in the country, existing resources, both human and material, advances in the mental health technology particularly in the field of delivery of health care to the people in the rural and far-flung areas and out come of research studies in various fields. Under this programme, it is envisaged that at least 200 million people particularly those belonging to the socially and economically backward areas of the country are likely to benefit.

The National Mental Health Programme has the following objectives :

1. To ensure availability and accessibility of minimum mental health care for all

in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

2. To encourage application of mental health knowledge in general health care and in social development.

3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

In order to achieve the above objectives, the programme has been designed to have the following approaches:

a) Integration of the mental health care service with the existing general health services ;

b) To utilise the existing infrastructure of health services to deliver the minimum mental health care services ;

c) To provide appropriate task-oriented training to the existing health staff ;

d) To link mental health services with the existing community development programme.

The programme will have three components, namely, treatment, rehabilitation and prevention of illness and promotion of positive mental health. The treatment programme has been planned keeping the primary health care approach as the sheet-anchor. At the same time, it consists of the creation of an appropriate referral system at various levels. It is proposed that the specialised psychiatric services should be made available at the district level. The other major responsibilities for the health personnel at the district level would be to provide training and supervision to the workers at the primary health centre level. The mental hospitals, medical colleges, teaching institutions and mental institutes shall also be linked together into the national grid for the mental health care particularly in the field of education and research.

The rehabilitation sub-programme will develop services for the rehabilitation of the chronically disabled due to mental illness as well as mental retardation. This programme envisages linkages with the rehabilitation programme of other Ministries particularly the Ministry of Labour and Social Welfare.

In the field of prevention and promotion, the sub-programme visualises counselling services for common mental health problems like alcohol and drug abuse, delinquency and genetically inherited mental illness.

The salient recommendations are :

a. Mental health must form an integral part of the total health programme and as such be included in all national policies and programmes in the field of health, education and social welfare.

b. Considering the importance of mental health in the total development of society mental health aspects should be kept in view in the planning of activities for national development.

c. Appreciating the importance of mental health in the course curriculae for various levels of health professionals, suitable action should be taken with the appropriate authorities to strengthen the mental health educational component.

d. The practitioners of Indian systems of medicine should continue to play their respective distinct roles in the field of health inclusive of mental health.

RECOMMENDATIONS OF THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE REGARDING NMHP

Recommendations made by the Central Council of Health and Family Welfare on Mental Health Programme in its meeting held on 18th to 20th August, 1982 are as follows :

The Joint Conference considered the importance of mental health in the total development of society and appreciated that mental health is an integral part of total health and it should therefore be viewed in that light. The Joint Conference recommends that :

1) Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of Health, Education and Social Welfare.

2) Realising the importance of mental health in the course curriculae for various levels of health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the Mental Health Education components.

CHAPTER 2

PRIMARY HEALTH CARE SYSTEM IN INDIA

We have adopted primary health care (PHC) approach to organise health care services in our country. In this approach, integration of all elements of development and welfare is made to make an impact on health status of people in the community. It includes preventive, promotive, curative and rehabilitative measures as well as community developmental activities.

The principles of primary health care are as follows :

1. PHC to be shaped around the life pattern of people.
2. PHC is an integral part of national health system.
3. PHC has to be integrated with other sectors which are involved in community development and in community welfare like agriculture, rural development, education, labour, communications, social welfare etc.
4. Local population is involved in formulation and implementation of PHC.
5. Maximum reliance on available community resources is encouraged.
6. Integrated approach of preventive, promotive, curative, rehabilitative services for the individual, family and community.
7. Interventions are made at the most peripheral level by suitably trained medical and paramedical workers who are supported by General Hospital and consultation hospital personnel.

Components of PHC

(According to Alma Ata Recommendations of 1978 to which India is a signatory state).

1. Addresses the main health problems in the community.
2. Promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation.

3. Maternal and child health care including family planning.
4. Immunization against major infectious diseases.
5. Prevention and control of locally endemic diseases.
6. Emergency services.
7. Promotion of mental health.
8. Provision of essential drugs.

Facilities at PHC

1. Out patient clinics on daily basis.
2. 4 – 6 beds for observation and emergency services.
3. Minor surgery equipments.
4. A small laboratory to do routine – basic investigations.

Manpower in PHC

Medical Officer of Health
(Administrative head)

Lady Medical Officer

Medical Officers
one of them can be from Indian systems of medicine.

1 Pharmacist

2 Staff Nurses

Block Health Educator
(Non-medical graduate)

Senior Male Health Assistants

Senior Female Health Assistants

(A senior worker with one year of training)

Multipurpose Health Workers – Males
(10 years of schooling + short training)

Multipurpose Health Workers-Females
(10 years of schooling + 18 months training)

Two Clerks and 2 Class IV staff

Though Sir Joseph Bhore Committee of 1946 recommended one PHC for every 40,000 population, even in 1989, it is still a dream in many parts of the country. On the average, in many states, one PHC serves a population of 80,000 to 1,00,000. Thus a primary health centre may have 4 to 6 medical officers, 6 to 8 senior health assistants (non-medical supervisory staff) and 30-40 multipurpose health workers.

Job Responsibilities of PHC Personnel

Multipurpose Health Workers (MPW) (Male and Female MPW)

MPW is the first contact person for the community regarding health care facilities. One male and one female worker serve a population of 5000. They live in one of the villages in the work area and carry out :

1. Curative services : Using 8–10 drugs, he or she offers first aid care to common ailments like fever, diarrhoea, aches and pains, injuries, deficiency states etc. They assist the patients to reach PHC as early as possible.
2. Identification and referral of patients with tuberculosis, leprosy, malaria, goitre, etc. and follow up of these cases.
3. Mother child health (MCH) activities including family planning.
4. Preventive and promotive activities like immunization, health education, etc.
5. Collection of vital statistics regarding births and deaths. Survey of diseases and disabilities from time to time.

Senior Health Assistant (SHA)

A senior MPW gets additional training for 1 year and gets prompted to become a supervisory staff. Each SHA supervises 4-6 MPWs. He or she guides, monitors, evaluates the work both in the field and in the hospital.

Block Health Educator (BHE)

He is a non-medical graduate and gets 3 months in-service training. He organises health education activities in the PHC area. He involves the community in the PHC programme. He helps the Medical Officer in conducting monthly review meetings at PHC and compiling the field and hospital data.

**Pharmacist* : A diploma holder in pharmacy, helps dispensing the medicines, and maintaining stock-register.

**Staff Nurses* : Help the Medical Officer in running the out-patient and inpatient services and give nursing care to the needy.

**Medical Officer of Health* : He or she is the leader of the PHC personnel, and is responsible to provide primary health care services to all in the community. He or she, looks after the medico-legal problems and also the administration of the PHC system.

PHC personnel are supervised and monitored by :

1. District Health and Family Welfare Officer and his assistants (both medical and non-medical) who are located at the district headquarters.
2. Divisional Joint Director of Health and Family Welfare and his assistants located at Divisional Headquarters.
3. Director and his team in Directorate of Health Services located at State capital.

Common Problems of PHC Systems

Though the infrastructure of the PHC system and functioning are well planned, there are many problems which affect the smooth functioning of the system. 'Health' is a state subject and unfortunately not a priority area for the allotment of funds. Each state allots only 1 to 6% the budget allotment to health sector. Govt. of India helps the states in planning and implementation of about 16 National Health programmes like tuberculosis control, malaria eradication, leprosy control, blindness control, nutrition etc. Most of the problems are related to :

1. Poor and/or inadequate buildings and space.
2. Lack and/or irregular supply of essential drugs.
3. Poor and/or inadequate in-patient and investigatory facilities.
4. Bad location of the PHC and is not easily approachable.
5. PHC staff may not live in the headquarters because of lack of basic facilities like housing, electricity, water, school, etc.
6. Many vacancies exist because trained personnel are not available or they may prefer to work in urban areas only.
7. Deficiencies in monitoring the care-programmes.
8. Poor or inadequate managerial skills of the concerned persons.

CHAPTER 3

DELIVERY OF MENTAL HEALTH CARE : SAKALAWARA EXPERIENCES

Systematic surveys of psychiatric morbidity in total populations carried out in various parts of the developing world have shown that the range and prevalence of mental disorders among these populations are comparable to those obtained from the developed countries (Leighton *et al.* (1963) in Nigeria, Giel and Van Luijk (1969) in Ethiopia, Lin (1953) and Lin *et al.* (1969) in Formosa, Dube (1970), Sethi *et al.* (1972) and Verghese *et al.* (1973) in India and Jayasundare (1969) in Srilanka.) They indicate that at any given time, about 2– 3% of the population suffer from seriously incapacitating mental disorders or epilepsy. Most of these patients live in rural areas remote from any modern psychiatric facility. The comprehensive reviews on psychiatry in developing countries by Carstairs (1973), Leon (1972), German (1972) and Neki (1973) about their respective areas of Latin America, Sub Saharan Africa and South-East Asia, have further highlighted the present status of mental health in their areas and have emphasized the need for better mental health services.

Often, better recognition of problems and availability of effective treatment methods do not result in better delivery of care for the needy population. The gross neglect of mental health needs of the population in the developing countries has been due to poor resources, lack of adequately trained personnel and in this context of overall shortages-higher priority given to killing, infectious and communicable diseases. It appears that for a long time to come the poor in developing countries will not have adequate resources to train and afford sufficient number of mental health professionals and organize a mental health care programme.

As a result of the recognition of the extent of mental health problems in the developing countries, several workers have developed innovative and successful programmes involving paraprofessionals and non-professionals in the delivery of mental health care in their respective countries (Schmidt, 1967 ; Dean and Thong, 1972 ; Swift, 1972 ; Climent *et al* 1978).

It has been suggested that 'basic mental care'—in the first instance of detection and

management of all psychotics and epileptics in the community—should be decentralized and integrated with the general health care services—the primary health care workers and rural doctors—could be trained to deliver 'basic mental health care' (Carstairs, 1973 ; WHO 1975 ; Giel and Harding 1976 ; Carstairs and Kapur 1976). To develop such a model the WHO has launched a multinational collaborative study in developing countries on 'Strategies for extending mental health care' (Sartorius 1977).

The WHO Expert Committee on mental health in its sixteenth report (WHO 1975) has recommended that "countries should, in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban population" and that "....training programmes including simple manual for the training of health workers should be devised and evaluated". Giel and Harding (1976) have suggested that the selection of priority conditions, setting of educational objectives for the appropriate health workers and designing of teaching manuals and methods, are the tasks of the local psychiatrists. Wig and Murthy (1978) have pointed out that no clear cut model is so far available for the delivery of mental health services and their feasibility has not been demonstrated in the setting of their country (India).

At the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, India, a programme for the delivery of mental health care in rural India through the existing health care channels is being organized by the Community Mental Health Unit of Department of Psychiatry, since 1976. The unit established a rural mental health centre at Sakalawara, a small village 15 km away from NIMHANS. A feasibility study was conducted in 122 villages covering a population of 75,000 with the following objectives and methods :

1. Identification of persons suffering from psychoses and epilepsy by asking a small percent of people in the community to name the patients who are in need of help.
2. Initiation of the treatment in the home setting, using five-six essential drugs.
3. The patient and the family members were asked to come to the centre at Sakalawara once or twice a month for follow-up.
4. Periodic evaluation of the treatment.

A team consisting of a psychiatrist, a psychiatric social worker and a psychiatric nurse conducted out patient clinics thrice a week at the centre. Both general patients with physical ailments and psychiatric patients were treated under one roof. The team visited the villages three days of the week.

The findings were as follows :

TABLE 1

Total number of villages covered—122.

Population : 75,649 (in 1980)

Year	No. of villages	Population	Patients detected or managed				Total
			Schiz.	Ac.Psyc.	MDP.	Epilepsy	
1977	50	39,000	14	4	10	85	113
1978	58	45,000	2	8	3	20	34
1979	100	65,000	20	8	8	98	134
1980 (9 m. only)	120	75,000	15	10	6	65	95
			51	30	27	268	376

TABLE 2

Duration of illness (Schizophrenia) before detection

Duration of illness	Male	Female	Total	
1—<2 years	0	2	2	4%
2— 5 years	7	7	14	
6—10 years	9	8	17	70%
11—15 years	2	5	7	
20 years and above	6	5	11	
	24	27	51	

96% were ill for > 2 years.

TABLE 3

Previous consultation in schizophrenic patients

Agency consulted	No. of patients	
Traditional healers only	23	
Traditional healers + doctors	3	
Traditional healers + NIMHANS	25	50%

All had consulted traditional healers

All were symptomatic at the time of detection

TABLE 4

Severity of disability in schizophrenic patients at the time of detection

Severe	: Patient doing no useful work/wandering/nuisance/has to be looked after.
Moderate	: Can take care of himself but doesn't do any useful work.
Mild	: Does some work by force
Little	: Patient is almost normal

Disability	Patients (Schizophrenia)	
Severe	24	86%
Moderate	20	
Mild	7	
Little	0	

TABLE 5

Acceptance of treatment (N = 51)	(Schizophrenia)	
Accepted	31	61%
Refusal of treatment	7	13.5%
Not traceable/wandered off	8	15.5%
Family moved out	3	6%
No treatment/and death	2	4%

TABLE 6

Response to treatment (31 patients) (Schizophrenia)

Disability	Initial		After treatment	
Severe	17	55%	0	
Moderate	12	39%	2	6%
Mild	2	6%	14	45%
Little	0		14	45%
Death		1		3%

TABLE 7

Number of child and adult epileptics

Age	No. of Patients	
<15 years	109	41%
15 years and above	159	
Total	268	

TABLE 8

Duration of fits

Duration	No. of Patients		
<6 months	37		14%
6—<12 months	17		6%
1—< 3 years	64		
3— 5 years	55		
6—10 years	52	80%	56%
11—20 years	27		
20 years and above	16		

TABLE 9

Previous consultation in epileptics

Agency consulted	No. of Patients	
Traditional healers only	102	38%
Doctor/Doctor + Traditional healer	94	35%
NIMHANS/N + 1 + 2	49	18.3%
Nil	29	8 7%

Conclusions

1. Majority of the patients identified were chronically ill and did not make use of the services available at NIMHANS though they were available freely within a distance of 5 to 20 km.

2. Almost all of them had consulted traditional healers for help. They had given up all hopes of getting cured. They were symptomatic and disabled at the time of detection.

3. Majority of them accepted the treatment and were managed at home with periodic follow-up at the centre.
4. Severe and chronic schizophrenics showed good response to treatment and were quickly rehabilitated by the family members.
5. Cost of treatment was curtailed by using a few inexpensive drugs like CPZ and phenobarbitone.

Persuasive efforts were necessary to make them accept regular and long term medication and follow-up.

Thus if this work can be taken up by PHC personnel as part of their work, it would be possible to give mental health care to the needy personnel in the community. PHC personnel are nearer to people, thus easily accessible, approachable and acceptable. It would be cost effective.

These issues were discussed with the administrators of Department of Health and Family Welfare, Karnataka. The advantages of integrating mental health care into the existing general health care system were brought to their notice. As primary health care includes the promotion of mental health (Alma Ata Declaration 1978) Govt. of Karnataka accepted this policy and became a model to the rest of the country. It made a request to NIMHANS to conduct two pilot training programmes to train PHC personnel in a short period and to demonstrate the outcome of such an exercise. Thus NIMHANS organized two pilot training programmes, one at Malur in Kolar District (50 km away from NIMHANS) during 1978–79 and the other at Anekal in Bangalore District (40 km away from NIMHANS) during 1980–81.

CHAPTER 4

FIRST PILOT TRAINING PROGRAMME FOR PHC PERSONNEL 1978-1979

The experience gained during the feasibility study of identification and management of priority mental disorders in 75,600 population living in and around Sakalawara villages helped to approach the State Department of Health and Family Welfare to accept the policy of delivering mental health care through PHC personnel. Accepting this attractive policy, State Government wanted two pilot training programmes to be conducted by NIMHANS to understand the feasibility and effectiveness of short term training courses for PHC personnel in basic mental health care. Thus the first pilot training programme was launched at Malur, a taluk headquarter-town in Kolar District situated about 48 km away from Bangalore. Malur was a field practice area for Family Planning Association of India (FPAI). Dr. Rama Rao, the chief coordinator of FPAI and other office bearer, of this voluntary organization took been interest in the programme. They were generoue to give space in their building to conduct the training. A short 'two days-weekend' courss was planned for PHC doctors and health workers in 1978.

Malur has a primary health centre, manned by 3 Medical Officers 5 local fund dispensaries (LFD), one Medical Sub-Centre and one Ayurvedic Dispensary. All the doctors, health workers of this set up as well as private practitioners of the area were invited to undergo the training.

Aims and objectives

The course aimed to teach the doctors the clinical features and management of psychoses and epilepsy. They were also taught the initial management of psychiatric emergencies like suicidal threats, acute excitements, status epilepticus and post partom psychosis. The aims of training the health workers were to remove the misconceptions about mental disorders and orient them to the modern understanding of these disorders and their management.

13 doctors (9 were working in PHC set up and 4 were General Practitioners) and 59 health workers underwent the training.

Out of 13 doctors, 9 had MBBS qualification, 2 had Ayurvedic, one had Homoeopathic and one had both ayurvedic and homoeopathic qualifications. Thus it was a mixed group and lead to a lot of problems which the unit did not realise in the beginning.

Pretraining Assessment

A questionnaire was prepared to elicit information from the doctors about the following topics :

a) causes of psychoses and epilepsy
b) management of these conditions
c) drugs and dosages employed to treat excited and depressed patients
d) clinical features of schizophrenia, mania and depression
e) distinguishing features between epileptic and hysterical attacks.
f) management of an epileptic fit when witnessed.
g) when to start and stop treatment for epilepsy and investigations needed to diagnose it.

The questionnaire was administered to all the doctors.

A knowledge and attitude questionnaire (see Tables 1-3 : Appendix 1) was prepared to assess the health workers. It consisted of (i) 20 statements which measured attitudes, nature-causes-treatment of mental illness and epilepsy which required yes, no or don't know responses, (ii) 8 probable causes of mental illness to be ranked in the order of their importance (iii) 6 possible treatment methods for mental illness to be ranked in the order of importance (iv) 8 possible modes of treatment of epilepsy to be ranked in the order of importance.

Findings of the Pretraining Assessment

Doctors : Non-MBBS doctors had some difficulty in communicating in English. None of the doctors believed that black-magic, masturbation, excessive sexual indulgence, lack of faith in God, bad stars were the causes of mental illness or that beating was a method of treatment. There was considerable variation in the ranking of various other causes of mental illness including too much work, presence of mentally ill in the neighbourhood, body weakness, heredity, head injury, broken love affair and worries. Marriages, diet restriction and religious treatment and restraining figured prominently as methods of treatment.

The answers on the drugs and dosages used were grossly unsatisfactory.

The questions on the clinical features of schizophrenia and mania were not answered by 4 doctors and other 6 were not clear in their answers either. The clinical picture

of despression was reasonably well described by five doctors. Six doctors mentioned that chlorpromazine was one of the drugs to treat epilepsy. No one had given correct answers for the starting and duration of treatment for epilepsy. Six had answered reasonably well about first aid measures in epileptic fit. No one had a clear idea about the distinguishing features between epileptic and hysterical attacks.

Knowledge and attitude of health workers will be given later along with the post training assessment.

Content and Methods of Training

The introductory session was common to both doctors and health workers in which the aims and objectives of the course were discussed. Later they were taught in separate sessions as the medium of instruction for health worker was Kannada, the state language. The second session for the doctors covered, nature, causation and broad categories of mental illnesses. The common psychiatric symptoms were illustrated with the help of short vignettes. Minimum technical words and simple language were used. This was followed by 3 sessions one each on schizophrenia, affective disorders and epilepsy lasting for 50 minutes (total 2½ hours). The emphasis was on symptomatology, diagnosis and management. Drug management was explained in some details but restricting the drugs to two or three only in each categories, identification of side-effects and their management were discussed. The last session was devoted to discuss the psychiatric emergencies. The programme came to an end after another joint session during which the follow-up and evaluation of the training was discussed. Simultaneously the nonmedical mental health professionals taught the health workers, in Kannada, identification, referral and follow up of mentally ill and epileptics in the community. The role of health workers in educating lay people about mental disorders was stressed. Lecture notes were distributed (cyclostyled copies) to the trainees as per their request.

Post Training Assessment

The same questionnaires were administered to the trainees and their responses were analyzed.

As anticipated, improved performance was most noticeable among the doctors with MBBS qualification. The ranking of the causes of mental illness and epilepsy became more consistent and appropriate. Medicines and improvement of family environment became the first and second choice of treatment for these conditions. In contrast to the pre-training answers, religious treatment and marriage were not mentioned as treatment methods. Satisfactory changes in the answers on drugs and dosages used in the management of excitement and depression were seen in half the participants. More accurate answers were given for epilepsy by most of them. The clinical features of mania and schizophrenia were better described but still far from satisfactory.

Answers regarding depression were fairly accurate. Distinguishing features between epilepsy and hysteria were well brought out. Thus the improvement among doctors with MBBS degree was noticeable, although their level of information was still not very satisfactory.

56 health workers completed both pre and post training questionnaires. The comparison of results are given in Table 1.

TABLE 1

	Total No. of Yes before the course	% of change from Yes to No after the course	Total No. of No before the course	% of change from No. to Yes after the course	Z value	Level of signifi-cance
	1	2	3	4	5	6
1. Have you seen mad people ?	55	0%	0	0%	—	NS
2. Are you afraid of mad people ?	25	96%	0	0%	7.22	0.001
3. If you were expected to look after a mental patient would you be scared ?	22	100%	0	0%	7.35	0.001
4. Mad people act the way they do deliberately	5	100%	0	0%	7.35	0.001
5. Mental illness is contagious	3	100%	0	0%	7.42	0.001
6. Mental illness is hereditary	8	50%	11	24%	1.52	0.10
7. Mental illness is incurable	15	47%	2	5%	3.77	0.001
8. Black magic can cause mental illness	18	72%	5	14%	4.29	0.001
9. Failure in love affair may lead to mental illness	54	7%	1	50%	—	NS
10. Death of a close relative may cause mental illness	45	4%	8	73%	5.30	0.001

	1	2	3	4	5	6
11. Financial problems can lead to mental illness	50	10%	4	67%	3.57	0.001
12. Worries may lead to mental illness.	50	4%	4	67%	4.69	0.001
13. Unemployment may lead to mental illness	49	6%	5	71%	4.62	0 001
14. Fright may lead to mental illness	44	23%	7	0%	3.76	0.001
15. Physical and nervous weakness may lead to mental illness	47	4%	8	100%	6.48	0.001
16. An excited patient should be confined to a room or tied up	48	15%	0	0%	3.90	0.001
17. By beating, the mentally ill person can be taught to behave properly	4	100%	1	2%	6.63	0.001
18. Do you know what fits are ?	50	0%	5	100%	7.42	0.001
19. Fits are contagious.	7	86%	2	4%	5.77	0.001
20. Untreated fits may lead to mental illness.	33	0%	15	83%	6.24	0.001

TABLE 2

Changes in the preferred modes of treatment for psychoses.

Mode of treatment	In conformity with expert's rating before the course	Not in conformity, initially, but changed to conformity after the course	Z value	Level of significance
1. Marriage	20	27(75)	4.66	0.001
2. Black magic	46	9(90%)	—	N.S.
3. Beating	55	1(100%)	—	N.S.
4. Drug treatment	55	1(100%)	—	N.S.
5. Ayurvedic treatment	28	19(68%)	3.49	0.001
6. Religious rituals	8	7(1.5%)	2.34	0.01

TABLE 3

Changes in the preferred modes of treatment for epilepsy.

	In conformity with experts ratings before the course	Not in conformity Initially, agreement but changed to conformity	Z value	Level of significance
1. Drugs	54	2(100%)	—	N.S.
2. Black magic	54	2(100%)	—	N.S.
3. Marriage	45	9(82%)	5.15	0.001
4. Ayurvedic treatment	19	15(41%)	1.87	0.05
5. Beating	55	1(100%)	—	N.S.
6. Branding	55	1(100%)	—	N.S.
7. Religious rituals	54	1(50%)	—	N.S.
8. Giving an iron object in hand	33	22(96%)	5.93	0.001

Most of the attitudes with the exception of items 1 and 9 showed change in positive direction at a statistically significant level. Fear of the mentally ill was decreased and the belief that psychosis was incurable was reduced. The belief that fits were contagious also lessened considerably (Table 2).

The belief that marriage was an effective treatment was significantly changed in negative direction. Ayurvedic treatment gained a higher status while drugs remained the preferred mode of treatment. The rankings given by the health workers before and after the course were compared to experts' rankings (see Table 2) with reference to mode of treatment, they gave I rank to drugs, II to ayurveda, III to religious rituals. Similarly ranking was done for epilepsy. The belief that putting an iron object in the patient's hand was a treatment as a treatment also changed significantly in negative direction (Table 3).

Conclusions drawn and lessons learnt

* It is possible to conduct 2 days training in mental health care for PHC personnel. Pre and post training assessment shows significant change in their knowledge.

* Duration is very short and most of the trainees felt that a lot of information was given in a short period and it was a little bit confusing.

* They wanted clinical demonstration of cases.

* For private practitioners, it was a loss of practice, as they had to attend the training programme from morning till evening. They preferred two or three 'half-a-day' sessions.

* Non-allopathic practitioners felt alienated in a programme oriented to a purely allopathic model. Thus it is better to conduct a separate programme for them.

* It is necessary to be emphatic and definite in the teaching given even at the sacrifice of pedantic accuracy, the ambiguities of academic psychiatry will have to be left out as far as possible in evolving this kind of training programme.

* The 'ranking of items' was not useful. It is extremely difficult even for qualified psychiatrists to rank the items. Thus it has to be omitted.

* There is a necessity to prepare a manual for doctors and health workers separately, one in English and another in Kannada as there is no appropriate literature for distribution to the trainees.

Follow–up

This training course was followed up for the next six months by monthly visits to the Malur PHC. The trained doctors and health workers were requested to come and discuss the work done and the problems faced. They were told to bring difficult cases for consultation. In these follow up meetings it was observed that, while severe cases of psychoses and epilepsy were identified, their numbers were lower than expected. The PHC team faced several problems in regularly following up these cases. The general practitioners showed less interest in attending these meetings. Thus the training mainly served as an orientation course for these personnel.

This exercise helped the team to prepare separate manuals for the doctors and healht workers and plan the second pilot training in a better way.

CHAPTER 5

SECOND PILOT TRAINING PROGRAMME FOR PHC PERSONNEL 1979–1980

The second training programme was conducted in the Anekal PHC of Bangalore rural district which is 50 km away from Bangalore City. This PHC had 5 doctors and 28 health workers. After initial consultation with the medical officer of health, it was decided to conduct the training for 2 doctors and 11 health workers who worked close to the PHC. It was not possible for the other personnel to assemble at PHC even once a week without interfering with their routine work. (The order from DHS stated that the pilot training had to be conducted without interfering with the routine work of the system).

Objectives

The broad objectives of the training for MPWs were to train them to do the following tasks :

1) Detect all cases of severe mental illness, severe mental retardation and fits in their respective areas of work.
2) Refer these cases to Anekal PHC.
3) Follow-up these cases once the doctor has started them on appropriate treatment.
4) Educate the family and community in taking care of these cases.
5) Attend the psychiatric emergencies and give them first aid.

The PHC doctors were trained to :

1) Diagnose and manage typical cases of psychosis, epilepsy, mental retardation with associated problems and psychiatric emergencies referred to them by the MPWs.
2) Refer cases which they cannot manage to the psychiatrist for further management.
3) Supervise the MPWs in the follow-up of all detected cases.

Method of Training

The training was completed in 15 weekly sessions of 2 hours each, 13 of which were for the training purpose and the remaining two for pre-training and post-training assessment. Separate sessions were simultaneously conducted for the doctors in English and MPWs in the state language, Kannada. These were held on a day of the week and time suggested by the doctors and MPWs as most convenient to them. The sessions were informal lectures based on the manuals, followed by discussion. All sessions were accompanied by either live case presentations or presentation of clinical stories. In later sessions many live cases were brought by the MPWs or doctors themselves.

Training Schedule of Health Workers

*90 minute session on every Wednesday.
one psychiatrist and one social worker conducted the training.

I	Session (5.10.1979)	: Administration of knowledge and attitude questionnaire.
II	Session (10.10.1979)	: Definition and causes of mental illnesses. How to take history.
III	Session (24.10.1979)	: Treatment of mental illnesses. Role of Health workers in involving family members in the long term treatment.
IV	Session (5.11.1979)	: Mental Retardation.
V	Session (7.11.1979)	: Epilepsy.
VI	Session (14.11.1979)	: Follow up of the patients.
VII	Session (21.11.1979)	: Psychiatric emergencies : First aid by health workers.
VIII	Session (28.11.1979)	: Demonstration of cases.
IX	Session (5.12.1979)	: Post-Training Assessment.

Observations : In general the health workers were found to be enthusiastic and keen to learn. The attendance was good. One or two workers missed one or two sessions as they were busy in attending to the problems in the field. They brought out their difficulties through the following questions :

1. How to convince the villagers who prefer to go to faith healers to get treatment, to come to PHC for help ?
2. Some elderly villagers make fun of young health workers when they try to advise them to follow modern methods of treatment.
3. What are the effects of tranquillizers on mentally retarded children ?

4. What are the factors during pregnancy which lead to mental retardation in the child ?
5. Can they say that there is a permanent cure for epilepsy ?
6. Should an epileptic patient continue to take anti-epileptic medicines when he suffers from physical illnesses ?
7. How antiepileptic drugs act ?
8. Are there surgical procedures to treat epilepsy ?
9. More details regarding drug dosage.
10. Whether they would be allowed to dispense the drugs ? If they are not allowed, people may reject their advice to seek help from PHC doctor.

In general, the participation and co-operation, the interest and enthusiasm of the health workers were satisfactory and encouraging. Except one health worker who is said to be irregular and inefficient otherwise also, others attend almost all the sessions. Many of them took notes while teaching was going on and actively asked questions and raised doubts. They did not think that it would be extra burden on them to do the job of detecting cases or following them.

Thus the health workers who work attached to the centre could be trained in their own set up without disturbing their routine work. But if the objective is to give training to all the health workers of PHC, it needs special effort and arrangement to make all of them to assemble at one place at a given time which may not be practicable without disturbing their routine work.

Assessment of Workers

A specially prepared questionnaire (Appendix 2) which can be self-administrable was used to assess the knowledge and attitude of the health workers about mental illness and epilepsy. The questionnaire was administered before and after training. On analysing the data, there is a definite change in their knowledge and attitude toward positive side, revealing that the training was effective.

Eg : (1) 7 out of 10 said that marriage could be a treatment for mental illness before training and only one said so after training.

(2) 9 out of 10 said that they would give an iron object to a person who threw a fit, before training and only two said so after training.

It was felt that the self-administered questionnaire was not reliable tool for the assessment. It was found that the health workers did not understand the questions properly and thus answered erractically. Eg : While answering for the question some gave what people would do. Thus it is advisible to use a *structured interview method for*

assessment which would be more reliable and meaningful. It is also felt that some of the issues need a little more explanation. Eg : Some of the workers were not impressed regarding drinking habit which could cause mental illness.

Assessment on different lines like (i) how many cases they would identify and refer. (ii) how effectively they would do the follow-up of these cases etc. have to be planned.

Training of Doctors

90 minutes session : One psychiatrist conducted the training.

I Session—Pre-training assessment.

II Session—Definition, types and causes of mental illnesses.

III Session—Signs and symptoms.
History taking and examination.
Live demonstration.

IV Session—Psychoses.

V Session—Psychoses.

VI Session—Mental retardation.

VII Session—Epilepsy.

VIII Session—Psychotic emergencies.
Referrals.

IX Session—Post training assessment.

Evaluation of the Training

The training was evaluated by an assessment of the theoretical knowledge gained by the trainees and enquiring into any attitudinal change which occured due to the training. This was achieved by comparing a simple post-training assessment of their attitudes and knowledge regarding mental health with their pre-training performance. The assessments consisted of two parts. The first part was administration of a questionnaire (Appendix—3) which inquired into their knowledge and attitude regarding causation and methods of treatment of severe mental illness and epilepsy. This part was identical for both the diagnosis and management of mental illnesses and epilepsy. The second part of the assessment for doctors consisted of presenting them with a series of simple clinical histories of different neuro-psychiatric conditions. They were required to answer certain questions based on these clinical histories on diagnosis and management—names, dosages and side effects of drugs etc. Definite answers for all the questions on all the clinical histories were formulated by the investigators and the credits for each correct answer was determined. Based on these, the answers of the doctors were assessed. Certain difinite

informations (contained in the manual of instruction) were expected and credits for this was determined. The assessment was based on this.

Results of the evaluation : Analysis of the pre and post-training performances of the doctors revealed that most of their answers to the first part of the assessment (attitudes, causes, treatment methods and investigations needed for mental illness and epilepsy) were satisfactory even before the training. But the post-training answers showed that the role of EEG, skull X-Rays and blood tests in diagnosing epilepsy and mental illness was clarified by the training. The second part of the pre-training assessment highlighted their ignorance regarding psychiatry. They were not able to correctly diagnose or name the drugs used for any of the cases in the clinical stories, mention correct names of drugs and dosage ranges, the commonest side effects of these drugs and their management. They also knew the necessary duration of treatment.

Lessons learnt

1. The PHC as the venue of an inservice training programme and the instructors travelling from their headquarters to the rural centre for purposes of training, as attempted in the present model, may not be feasible on a larger scale. Although this model has the advantages of the setting of training being very real, the availability of clinical problems as they present in the PHC, and the doctors and MPWs not having to stay away from their routine work, it presented the problem of the trainees not being able to fully concentrate on the training due to their routine pressure of work. They should be deputed to undergo training in a centre away from their work area.

2. The case material available in the PHC was predominantly of the non-psychotic, non-epileptic variety, while the primary aim of the training was to equip the doctors and MPWs with adequate knowledge on identifying and managing on a long term basis, the untreated epileptics and psychotics in the community. Hence, either the trainees are asked to identify and bring such cases for discussion or conduct a mental health camp. The purpose will not be served.

3. Although management of the epileptics and psychotics was the primary aim of the training, the PHC doctor came across a large number of non-psychotic psychiatric conditions which he could not satisfactorily manage. It is worth considering whether management of non-psychotic psychiatric problems should form an important part of the training.

4. A long term evaluation of the work done by PHC personnel has to be planned.

Follow-up

The lady Medical Officer got transferred within two months after the training. The male Medical Officer started identifying psychiatric problems among the patients who

came to the centre for medical help. He referred many of these cases to the experts as he felt difficult to manage the neurotic disorders. This lead to a need of starting a fornightly clinic at Anekal by Community Mental Health Unit. The clinic in no time began attracting neuro-psychiatric cases in large number. Within three years, the team had to arrange two clinics a weeks to meet the demands. The services offered were appreciated and better made use of by the community. But the unwanted development was, the PHC personnel's preference to work as 'referral agents' rather than to work as care givers. This was because, the specialist team went regularly to the clinic and the message spread to people was – 'NIMHANS team run the clinic'. The PHC personnel felt convenient to to refer the cases.

CHAPTER 6

TWO WEEKS TRAINING IN MENTAL HEALTH CARE AT RURAL MENTAL HEALTH CENTRE, SAKALAWARA FOR PHC PERSONNEL—APRIL 1982

After receiving the reports of two pilot training programmes, the Govt. of Karnataka took a decision to depute PHC personnel for 2 weeks to undergo training in mental health care at Rural Mental Health Centre, Sakalawara where it had funded to develop it as a training centre. The Directorate of Health Services was instructed to depute PHC personnel from 4 districts of Gulbarga Division. This division was chosen on priority (There are totally 4 divisions with 20 Districts in Karnataka) because this area was troubled by 'Bhanamathi' a type of witchcraft. The report of Bhanamathi investigation committee headed by former Vice-chancellor of Bangalore University Dr. H. Narasimhaiah had clearly stated that 90% of the victims of Bhanamathi were actually suffering from different mental disorders and the mental health services in that area were almost non-existant. The committee had recommended to train PHC personnel in mental health care so that they could help the victims. The first batch of the trainees came on 19-4-1982 which consisted of 6 doctors and 11 health workers (photo).

The training programme was officially launched in April, 1982 by Chief Minister of Karnataka and the function was graced by dignitories like, Mr. Kagodu Thimmappa, Minister for Public Works Mr. Abdul Samad, Minister for Health and Family Welfare, Government of Karnataka.

The content and duration of the training programme were decided keeping in mind the objectives of training PHC personnel and feasibility of them getting deputed without causing noticeable difficulties in the work area.

1. The training period was 12 working days. It would start on a Monday and end on a Saturday of the next week.
2. It was a residential programme at Sakalawara Centre, thus minimising the movement and distraction of the trainees.
3. District Health & Family Welfare Officers were requested to send two doctors and four health workers from one PHC every month.
4. Doctors and their workers would undergo training together so that they would be clear regarding their roles in the programme and support each other.

5. A few topics were discussed in combined sessions. This was believed to encourage the team-spirit. Health workers were taught in Kannada and doctors in English.

6. Methods of teaching included a) class room lectures, discussions, case demonstrations in Sakalawara Clinic, Anekal Clinic and at NIMHANS, field visits and casework ups and daily feedback regarding the day's activities as well as preparation of health education materials.

7. Evaluation by pre and post training assessment using

   a) a knowledge and attitude questionnaire with 44 items (for both doctors & health workers). (Appendix-4).

   b) 6 case histories (for doctors only). (Appendix-5).

8. Contents of the programme were :

   For doctors : What is mental illness, signs & symptoms, History taking and examination. Management of Psychoses, Neuroses, Mental Retardation, Epilepsy, Legal aspects, referrals, Record Keeping, Mental Health Education. Role of PHC in Mental Health Care.

   For MPWS : What is mental illness
   Different types of presentation of mental illness and their treatment.
   Psychoses, neuroses, M.R. & Epilepsy.
   Common Misconceptions, Evil spirits, Bhanamathi and other craft.
   Responsibilities of MPWs.

9. Mental health professionals involved in the training were

   a) 2 Psychiatrists.
   b) 1 Clinical Psychologist.
   c) 1 Psychiatric Social Worker.
   d) 1 Psychiatric Nurse.

10. Teaching materials used :

   a) Chalk and black board.
   b) Slides for each topic.
   c) Small charts.
   d) Video recorded case-materials.
   e) Manuals.
   f) Case work-up proformas (Appendix – 6, a, b, and c).

11. Feedback and evaluation of the training course by the trainees (Appendix-7).

At the end of training 62 persons in 4 batches (I batch 21, II batch 21, III batch 14 and IV batch 6) the time table was as follows :

Day	9.00 to 10.30 am	11.00 to 1.00 pm	2.00 to 5.00 pm
Monday	Reporting	Settling at Sakalawara	Pre-training assessment
Tuesday	Introduction to Trg. prog. (combined)	Magnitude of Mental Health problems in our country (combined)	Community Mental Health activities at Sakalawara (combined)
Wednesday	Features of Mental illness (Health Workers)	Causes of mental illness & common misconceptions regarding this among people (combined)	How to examine mentally ill persons (combined)
Thursday	Epilepsy (Health Workers) Psychoses (Doctors)	Field visit to see cases (combined)	Discussion of the case materials (combined)
Friday	Psychoses (Health Workers) Organic Psychoses (Doctor)	Field visit (combined)	Free Time
Saturday	Education and involving village leaders (combined)	Mental Health Edn. (Principles) (combined)	Visit to Anekal Clinic
Monday	Field visit to identify neuroses (combined)	Field Visit (combined)	Preparation of Health Education materials (HO) Management of neuroses (Doctors)
Tuesday	Childhood Disorders (combined)	Mental Retardation (combined)	Bhanamathi (witch craft) Possession (combined)
Wednesday	Work-up of cases	in NIMHANS wards	Free Time
Thursday	Legal aspects of Psychiatry (combined)	Visit to Rehabilitation Centre and MR Clinic (combined)	Video-recorded case discussion (combined)
Friday	Preparation of educational materials (HW) Psychopharmacology (doctor)	Mental Health Edn. Lectures by Trainees (combined)	Problems in implementation of mental Health Programme at PHC level : discussion (combined)

Saturday	Post Training Assessment (combined)	Feedback discussion (combined)	Certificate Distribution (combined)

When the programme was reviewed at unit level, the training staff made the following observations and suggestions :

1. Both the doctors and health workers did not appreciate the combined sessions. Health workers experienced difficulty in expressing their views and doubts in front of their medical officer. Doctors felt uneasy to sit along with their health workers and preferred to maintain the hierarchy.
2. Doctors did not appreciate the usefulness of making home visits and see patients in the villages.
3. Doctors wanted more case demonstrations and more working up of cases in the clinical setting. Both of them wanted more video case demonstrations.
4. Both of them did not appreciate having to give a daily written or spoken report of day's activities. When they were made to write the report, they wrote simply 'good/satisfactory' etc.
5. Both the doctors and health workers wanted a lecture on structure and functioning of Brain and Mind.
6. Doctors did not appreciate non-medical mental health professionals taking classes for them.
7. Doctors expressed the desire to know more about management of neuroses, head injuries and other neurological problems like headache, stroke.
8. Health workers used to show more interest to know about drugs-dosage, side effects and openly expressed that they should be allowed to dispense the drugs to the patients.
9. Most of them expressed that duration of training was short and it should be 3 or 4 weeks.
10. All of them opined that it was a useful programme and suggested that every primary health care personnel should undergo training.
11. All of them said that the success of the implementation of the mental health care programme depended on :
    a) Availability of free drugs in the PHCs.
    b) Involvement of all types of PHC personnel.
    c) Administrative support and DHO and other senior officers at DHS level.
    d) Mental health education and increased awareness of people through different media like radio, press, cinema etc.
12. Slides could not be used becauses of frequent power failures.

13. Some appreciated the venue—being away from city, calm and serene atmosphere but many expressed that they would have loved to stay in the city and they got bored as the centre was away from it.

14. They enjoyed the pre and post training assessment exercise though many of them were hesitant and apolegetic during the pre-training period telling that their answers (no answers) would expose their ignorance in the area. They wanted to know their rating and staff's opinion regarding their performance.

15. They suggested that their seniors and administrators should be oriented to this programme.

A few changes were made in the curriculum of the programme like session :

1. Introduction of a) Expectation of the trainees from the programme.
   b) Brain, mind and behaviour.
2. Omission of village visits to doctors and increased case work up in the clinical setting.
3. Stopping 'comments on day's activities'.
4. Minimising the number of combined sessions.
5. One page record sheet for health workers and monthly report forms were designed for PHC doctors and health workers. They were supplied to them with a request to send it to NIMHANS every month. Appendix—8 and 9.

CHAPTER 7

EVALUATION OF THE TRAINING PROGRAMME

At the end of one year the unit was fairly satisfied regarding the training courses. Most of the trainees expressed that they were benefitted by the training and had assured that they would certainly start mental health care activities in their respective centres. Now and then a couple of them had written letters regarding the difficult cases they were trying to manage. None of them sent the monthly report as expected. The efficacy of the training programme has to be seen in the field. Therefore it was decided to visit a few primary health centres of these 4 districts where trained doctors were working. It was suggested that the evaluation had to be made in informal way by surprise personal visits. In the month of April 1983, two teams went out to these districts, which consisted of the following members :

Dr. G. N. Narayana Reddy, Director, NIMHANS.
Dr. Krishna Iyengar, Divisional Joint Director, D.H.S.
Dr. C. R. Chandrashekar, NIMHANS.
Dr. R. Srinivasa Murthy, NIMHANS.
Dr. Mohan K. Isaac, NIMHANS.
Dr. Muralidhar, A.D.H.O., Bellary Dist.
Dr. Abdul Gafoor, DHO, Gulbarga.

Trained doctors and a few health workers in 15 PHCs were met and were enquired about their mental health work. No attempt was made to assess their theoretical knowledge. An attempt was made to understand their attitude towards the programme, how many cases they had treated, the type of problems faced, the type of support they looked for from their department and NIMHANS and the suggestions given to improve the programme. Though this is not a very scientific method of assessing the programme, it threw light on difficulties and problems which were not given due importance by the unit. The following observations were made :

1. None of them felt that providing mental health care along with other health care activities was an additional burden. One third of the doctors were treating 5 to 15 cases who were improving. They could call a few of thes patients and demonstrate to the visiting team.

2. Except three doctors, none of them was maintaining any record of the patients at PHC. All of them wanted simple case records to be supplied to them.
3. In most of the places, there were no essential drugs. Only Phenobarbitone was available in small quantity in about 60% of the PHCs.
4. They said that they did not sent the monthly report about mental health programme because nobody reminded them and they did not had a format to do so.
5. 2 doctors said that they did not take the programme seriously because none of the administrators enquired about it in the monthly meetings. They clearly told that unless there was a directive from the DHO or DHS, the programme might not be taken seriously by PHC personnel.
6. A few health workers who were met, told that they were identifying cases and had mixed results in referring them to the PHCs. Some would come and get treated, some would refuse, having no faith in modern medicines. They said that every PHC personnel should be trained, and the supervising staff had to be sensitized regarding supervision of this programme.
7. Every trained person talked about the need of educating the community about this programme and wanted mental health education materials like posters, slides, 16 mm films etc. They suggested that mass media had to be involved in educating the people in this regard.
8. Consultation services should be available at least in the district hospital for difficult psychiatric patients.

By the end of December 1983, 19 batches consisting of a total number of 59 doctors and 140 health workers had the training in mental health. With the experience of conducting training for 19 batches and assessing their performance as well as the feedback obtained not only from the trainees but also from the postgraduate trainees and colleagues, the following changes were made :

1. It was decided to hold the training programmes for doctors and health workers separately.
2. Keeping in mind the job responsibilities and the large number of MPWs to be trained, the duration of training was reduced to six working days.
3. The days on which the doctors work up cases and discuss were increased to $3\frac{1}{2}$ days.
4. 6 hours were allotted to start a new exercise for doctors wherein they carry out a mental health education activity for health workers in a 'role play' situation.
5. A new session on 'General approach to psychiatric patients' was introduced for both doctors and MPWs.

6. A new topic 'Emotional reactions to physical ailments and hospitalization' was introdued to the doctors programme.
7. More video materials were used along with lecture sessions.
8. Role play session was introduced to MPWs wherein they would demonstrate how they could educate the patient and his family members regarding mental disorders and their management.
9. Most of the organization of the training programme and training for health workers were carried out by the Nursing Staff of the unit with minimum involvement from other faculty members. They were appropriately trained for these tasks.
10. Importance and method of keeping the records and reporting were discussed with the trainees. A few materials were given to them for initial use. (Like revised case register book for MPWs (Appendix 10).
11. Pre and post-training assessment of the doctors were done by using videol materials instead of written case histories. For health workers, in addition to the knowledge and attitude questionnaire, another semistructured questionnaire to assess their knowledge about mental disorders was designed and used. Appendix 11a, 11b and 11c.
12. For health workers, programmes schedule was revised so that they spend one day to learn about psychoses through class room teaching followed by field work in the villages and seeing the patients along with the family members and similarly they spend another full day to learn about epilepsy. They found this very useful. (Appendix—12).
13. All efforts were made to keep the relationship between the trainers and trainees as informal and friendly as possible. This was appreciated by every one.

The training programme was continued. Almost every month, batches of trainees came. In August 1984, in addition to the Districts of Gulbarga Division (except Bellary District, where PHC personnel got trained either at district headquarters or taluk centre as part of District Mental Health Programme) districts of Mysore Division (Mysore, Mandya, Kodagu, Dakshina Kannada and Hassan) were included. Thus the size of each batch of trainees increased. The content and methods of training remained almost same except a few modifications. Record sheets for doctors and health workers (Appendix 13, 14) were prepared and supplied. In addition to the already existing evaluation questionnaire, a multiple choice questionnaire for doctors was added (Appendix 15).

The common administrative problems met are :

1. To get trainees in sufficient number : Many times, suddenly a few district's

DHOs would not send the trainees and the batch would be very small. It was decided to send a letter to each DHO mentioning whether trainees came (if so, who and from where) or not and requesting him to send trainees for the next month, reminding him the dates of training programme. (Appendix 16) Half a day orientation meeting was organised at Sakalawara Centre for all the DHOs of the divisions and they were requested to support the programme. This helped in improving the process of deputation. Attendance increased. When the list of trainees from DHOs came in advance, a letter was written to the trainees reminding them to report to the training coures without fail (Appendix 17).

2. Many trainees complained that they were informed about the programme very late and they had to take difficult decision of either accepting or rejecting the order with a request for another date. They were not given advance TA/DA and health workers had financial difficulties. DHOs were requested to send the order of deputation at least 2 weeks in advance and also sanction advance TA/DA. Programme dates were given for the whole year to facilitate this. But in spite of the best efforts, in most of the cases advance TA/DA was not available and this was one of the reasons for some health workers' inability to attend the programme.

3. Trainees later complained that they might have to wait for 6 to 12 months or even more to get TA & DA. Sometimes they might not get the full money because the department might suddenly dec ide to pay 50 or 60% of the bill. However, this was not unique to this programme. This was a general problem.

4. Because of the administrative pressure regarding targetted programmes like Family Planning, every body in the department gave top priority to that programme and the needs of the mental health programme were neglected or postponed about which they expressed their helplessness.

5. When certain public health emergencies occured like Cholera and Gastro-intestine disorders, sudden increase in the cases of malaria, DHOs expressed their inability to depute doctors from that area. But they could have taken decision to depute people from other areas where there was no such emergencies. Thus it appears that DHOs commitment to the programme is very essential for regular deputation of PHC personnel.

NIMHANS and the Department of Psychiatry made use of every opportunity to meet DHOs and other administrators at DHS and remind them for their active involvement in the programme.

II Review visits to PHC

In December 1985, a review visit to a few PHCs in Mysore Division was planned

with the active support of the Department of Health & Family Welfare, Karnataka. Based on the earlier experience in Gulbarga Division, a 'guided interview schedule' (appendix 18) was constructed. The team members consisted of Dr. G.N. Narayana Reddy, Dr. Mohan K. Isaac, Dr. Srinivasa Murthy R, Dr. Sunder Moily, Dr. Leelavathi Devdas, Divisional Joint Director and two of her deputies.

The team visited 10-12 PHCs and collected the information. It also randomly examined a few patients under the management of the doctors. The guided interview attempted to assess

i) the mental health work done (identification), management of cases, health education.
ii) the kind of problems faced.
iii) the impressions regarding the training.
iv) their remedial suggestions.

The duration of field visit was 3 days and on an average the team spent 40-60 minutes in each centre. During the visit, health administrators also interacted with the PHC personnel. The observations made were almost same as those made in Gulbarga division but the quality of work done by Mysore division was better. This may be because even otherwise the health care activities of the PHC personnel in this division is better, the reason being general living standards are better (Gulbarga division is more backward than others in the state). Roughly 1/3 turned out not so good work and the remaining 1/3 in between. The record keeping in general was far from satisfactory by both doctors and health workers.

The health workers reported the following problems :

a) Since only a small number of them were trained from each PHC and majority were not trained, there was no pressure or atmosphere to take up this work seriously.

b) They reported that the pressure from authorities is so heavy on programmes like family planning, malaria, immunization, mental health programme got neglected.

c) People were not convinced about the efficacy of PHC personnel in treating these cases.

d) In many places, the doctors were not trained.

e) In general, health workers were unhappy regarding the support and guidance from the doctors who according to them were more practice oriented than service oriented.

Thus the health workers' contribution to mental health care was limited.

The suggestions to improve the programme were again (1) Train everybody (2) Provide drugs (3) Give mental health education material (4) Introduce reporting system and regular monitoring from DHO & DHS (5) More frequent visits by NIMHANS team. (6) Hold mental health camps (7) Arrange periodic refresher courses.

With all these inputs, the deputation of doctors and health workers was streamlined and each batch became bigger and bigger and the unit found it difficult to manage as the number increased to 24 doctors and 33 health workers. The unit had to struggle to arrange food and accommodation, transport, clinical teaching to such a big group.

The training of health workers was almost managed by the nursing staff of the unit with marginal support from other disciplines.

The training was managed by two GDMOs (psychiatrist) and one faculty member from the Department of psychiatry. The curriculum are as follows :

Community Mental Health Unit, Department of Psychiatry–NIMHANS
Training in Mental Health Education for Health Workers

Monday	9 to 12 AM	:	Reporting and preassessment.
	1.30 PM	:	Meeting staff at Sakalawara, Details about programme and Centre.
	2–3 PM	:	NIMHANS documentaries.
	3–4 PM	:	Brain and Behaviour.
	4–5 PM	:	What is Mental Illness ? Video films.
Tuesday	9–10.30 AM	:	Psychosis, symptoms and identification. Video films.
	10.30–11.30 AM	:	Symptoms of depression, causes of psychosis.
	11.30–1 PM	:	Management and treatment of mentally ill patient.
	2–5 PM	:	Village visit – Discussion with patients Details about treatment.
	7–9 PM	:	Screening of feature film *Manasasa Sarowara.**
Wednesday	9–11 AM	:	Epilepsy, causes and treatment.
	11–1 PM	:	Mental health education, material preparation.
	2–5 PM	:	Village visits and discussion with patient family.
	7–9 PM	:	Screening of feature film *Sharapanjara.**

Thursday	9–10.30 AM	:	Neuroses, Psychological problems of physically ill patient and management.
	10–1 PM	:	Mental Retardation—and associated childhood disorders. Screening of films (Child & its mind).
	2–5 PM	:	Visit to Anekal Primary Health Centre Interview with mentally ill.
Friday	9–12.30 PM	:	Ward visit in NIMHANS—Interview with patients.
	2.30–5 PM	:	Role Play—Training in health education.
	7–9 PM	:	Screening of feature film *Yeradu Mukha.**
Saturday	9–10 AM	:	Post assessment.
	I0-11 AM	:	Community participation in mental health Programmes.
	11–12.30 PM	:	Discussion on implementation of programme.
	2– PM	:	Distribution of certificates and feedback.

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* These are regular feature films with mental health themes, made in Kannada.

Training in Mental Health Care for PHC Doctors :
2 Weeks Duration

Days	9.00 to 11.00 AM	11-15 to 1.15 PM	2.15 to 3.30 PM	3.45 to 5.00 PM
Monday	Reporting	Introduction and Aims of Training Programme	Pre-training Assessment at Sakalawara	NIMHANS films & Film on 'Forgotten Million'
Tuesday	Brain & Behaviour	Definition of mental illness, classification and causes	Signs & Symptoms of Mental illness Video-Case demonstration	
Wednesday	History taking & M.S.E. at Sakalawara O.P.D.	Schizophrenia	M.D.P.	Organic Psychosis
Thursday	ECT at NIMHANS	Work up of cases in the wards	Work-up of cases in the wards	
Friday	Work-up of cases at NIMHANS		Library Time	
Saturday	Epilepsy	Febrile convulsions	Visit to Anekal Mental Health Clinic	

II WEEK

Days	9.00 to 11.00 AM	11.15 to 1.15 PM	2.15 to 3.30 PM	3.45 to 5.00 PM
Monday	Identification of Neuroses in Sakalawara O.P.D.	Types of Neuroses	Management of Neuroses	Counselling
Tuesday	Childhood Mental Disorders	Mental Retardation	Sexual Inadequacies	Drug Abuse
Wednesday	Legal aspects of Psychiatry	Case work in NIMHANS O.P.D.	Case work up	Case work up
Thursday	Rehabilitation Centre at NIMHANS	M.R. Clinic	Case work up in wards	Case work up in wards
Friday	Training health workers, village leaders	Mental Health Education	Role play in training M.P.W.	
Saturday	Psychopharmacology	Post Training Assessment & Feedback	Problems in implementation of NMHP Certificate distribution	Departure

Manual of Mental Health for Medical Officers

After nearly 12 revisions, the Manual of Mental Health for Medical Officers was printed in 1985. The manual consists of 10 chapters namely 1) Mental Health as part of General Health (2) Brain and Behaviour (3) Mental Disorders (4) History taking and Mental status examination (5) Major Mental Disorders (6) Minor Mental Disorders (7) Childhood Mental Disorders including Mental Retardation (8) Epilepsy (9) Treatment of Mental Disorders and (10) Implementation of MHC at PHC. It also contains appendices like Responsibilities of Health workers in Mental Health Care, Mental Health Education, case records and Training time table.

Sufficient care is taken to give clear cut guidelines of management for each disorder. The doctor is informed regarding how to make diagnosis, how to initiate the drug and other treatment, how to follow up, when and how to refer, what is the prognosis and the importance of rehabilitation. Appendices like responsibilities of health workers and mental health education help the doctor to guide and superwise paramedical staff in mental health care.

Manual of Mental Health for Multipurpose Workers

This was printed in 1985 with the financial assistance by ICMR Advanced Centre for Research on Community Mental Health. Before coming in print, the manual had undergone 12 revisions. The manual consists of the following chapters :

1. Mental Health as part of general health care.
2. Brain and Behaviour.
3. Mental illness : Features, type, causes and treatment.
4. General approach to the mentally ill.
5. Psychoses.
6. Epilepsy.
7. Neuroses
8. Mental Retardation.
9. Mental Health Education.
10. Responsibilities of Health Workers.

Very simple and non-technical language is used. This manual has to be translated into regional languages so that health workers find it easy to read and understand. Already Kannada and Hindi version of the manual are available. Each chapter has one or two boxes in which salient points of the chapter are given so that the health worker is reminded about the same. At the end of the manual, a few mental health slogans are given to encourage health workers to make their own mental health education materials.

Both the manuals are available on request from community mental health unit, NIMHANS, Bangalore.

CHAPTER 8

DESCRIPTION OF THE TRAINEES

Details of thetrainees pre and post-training assessments

DOCTORS

TABLE 1

Year and District wise distribution of the Trainee - Doctors

GULBARGA DIVISION

Year	Bellary*	Raichur	Gulbarga	Bidar	Total
1982	6	11	9	1	27
1983	4	10	8	1	23
1984	–	1	5	–	6
1985	1	5	9	–	15
1986	–	22	16	2	40
1987	–	28	10	15	53
	11	77	57	19	164

* The remaining doctors were trained at Bellary itself as part of District Mental Health Programme.

TABLE 2

MYSORE DIVISION

Year	Mysore	Mandya	Kodagu	Hassan	D.K.	Total
1984	9	6	2	–	–	17
1985	8	14	9	14	10	55
1986	5	14	1	–	7	27
1987	11	12	10	31	14	78
Total	33	46	22	45	31	177

* Other Districts : 12.

TABLE 3

Sex Distribution

Male	301	85.3%
Female	52	14.7%
Total	353	

TABLE 4

Age Distribution

<25 Years	8	2.3%
26 — 35 Years	176	50.0%
36 — 45 Years	125	35.4%
46 Years & above	44	12.3%
Total	353	

TABLE 5

Qualification

Qualification	No. of Doctors	%
MBBS	252	71.4
MBBS with Diploma	57	16.1
MD/MS	27	7.6
Ayurvedic, Unani etc.	17	4.8
Total	353	

TABLE 6

Duration of Service

Duration	No. of Doctors	%
<1 Year	40	11.3
1—5 Years	137	38.8
6—10 Years	83	23.5
11—20 Years	76	21.5
21 + Years	17	4.8
Total	353	

TABLE 7

Total Number of Batches :	Doctors : 57.	Health workers : 56.
Range of Trainees in each batch :	Doctors : 1 to 20.	Health workers : 2 to 34.
Average number of Trainees per batch :	Doctors : 6.	Health workers : 10.

First 19 batches : Doctors & Health workers came together ; Later separately.

HEALTH WORKERS

TABLE 8

Year wise distribution of Trainee Health Workers

GULBARGA DIVISION

Year	Bellary*	Raichur	Gulbarga	Bidar	Total
1982	13	24	22	11	70
1983	7	19	26	4	54
1984	—	2	—	—	2
1985	—	8	12	–	20
1986	—	19	15	—	34
1987	—	74	15	17	106
Total	20	146	90	32	288

* Later they were trained in Bellary as part of District Mental Health programme.

TABLE 9

MYSORE DIVISION AND OTHER DISTRICTS

Year	Mysore	Mandya	Kodagu	D.K.	Hassan	B'lore	Dharwad	Belgaum	Total
1982	—	—	—	—	—	5	—	—	5
1983	—	—	—	—	—	4	6	2	12
1984	—	6	4	—	—	—	—	—	10
1985	18	15	19	31	23	—	—	—	106
1986	9	22	—	13	—	—	—	—	44
1987	9	44	11	10	33	5	—	—	112
Total	36	87	34	54	56	14	6	2	289

TABLE 10

Sep Distribution

Male	398	68%
Female	185	32%
Total	583	

TABLE 11

Age Distribution

<25 years	70	12.5%
26—35 years	228	40.6
36—45 years	225	40.1%
46+	38	6.8%
Total	561*	

* Information not available for 22 workers

TABLE 12

Education

10 years schooling	24	4.1%
SSLC	403	69.1%
PUC & +	82	14.0%
Graduation	50	8.6%
Not known	24	4.1%
Total	583	

TABLE 13

Duration of Service

0—1 Year	20	3.4%
1—3 Years	79	69.5%
4—9 Years	90	15.4%
10—15 Years	201	34.5%
16—21 Years	118	20.4%
22 + Years	53	0.1%
Not known	22	3.8%
Total	583	

Pre–Training Assessment of Doctors

TABLE 1

CLINICAL HISTORY No : A.1.

1. 17 year old male student, comes with parents.
2. Duration of Symptoms – 1 year.
3. One year ago, soon after lying down to sleep : he screamed.
4. He was then found to be unconscious.
5. All his four limbs were held straight and jerking in rhythmic fashion.
6. He had passed urine while unconscious.
7. He soon became conscious but remained dull for the day.
8. Had one more such attack 6 months ago, two more in the last 3 weeks.

Out of 132 doctors, number of doctors who wrote.

Correct Diagnosis (Epilepsy)	Chose Phenobar-bitone	Prescribed 60 mg./day	Mentioned side effect –Drowsiness	Advised bed time dose + Reassurance	Duration of treatment 5 years after last fit
117	113	82	79	53	60
88.6%	85.6%	62%	60%	40%	45%

TABLE 2

CLINICAL HISTORY No : A.2.

1. 20 years old married, housewife.
2. Duration of symptoms 2 years, and more since 6 months.
3. Attacks of bouts of belching varying in periodicity and duration.
4. She got married 2½ years ago.
5. She has a 7 months old baby girl but wanted a male baby.
6. She is free of symptoms for a few months at a time whenever she visits her parents or parents visit her.

No. of doctors who wrote.

Correct Diagnosis (Hysteria)	No drug/place to	Minor Tranq. like Diazepam 5–10 mg a day
72 54.5%	55 41.6%	23 17.4%

TABLE 3

CLINICAL HISTORY No. A.3.

1. 30 years old man, merchant.
2. Since 2 years, he is having pain abdomen which come at any time of the day but never during night.
3. He has consulted many doctors, special X-rays have been taken but no abnormality detected.
4. He has neglected his business and always worries about his illness.
5. His mother died 2 years back due to cancer of the stomach.

No. of doctors who wrote.

Correct diagnosis (Neurosis)	Prescribed Minor Tranq like Diazepam 5-10 mg.	Duration of Treatment 2 months	2 months-6/12
65 49.2%	51 38.6%	11 8.3%	34 25.8%

TABLE 4

CLINICAL HISTORY No. A. 4.

1. 32 years old factory worker was known to be a reliable, good worker.
2. From 4 months he does not do his work but goes round the factory advising others and offering his help to others.
3. He claims that he is the Manager and in a short period would own a factory. He assures that he would give two salaries to every worker in his factory.
4. He has become quarrelsome and a week back threatened his supervisor that he would kill him.
5. He is irregular in taking food and keeps the tape-recorder playing throughout night.
6. This is the third episode ; he recovered within 4-5 months in the earlier episode.

No. of doctors who wrote.

Correct Diagnosis (Mania)	Chose CPZ	Chose Other Anti-Psychotic Drug.	Chose Dose of CPZ — 200-400 mg	Mentioned side effects like EPS, Antichol, effects	Wrote Antiparkin Drug.	Treatment Duration 3-6 Months
45 (34%)	73 (55.3%)	Nil	43 (32.5%)	48 (36.4%)	25 (18.9%)	26 (19.7%)

TABLE 5

CLINICAL HISTORY No. A.5

1. 36 years old housewife with 3 children and a living husband.
2. Duration of symptoms — 3 months.
3. Loss of sleep.
4. Does not get sleep after 2 a.m. whereas previously she used to sleep till 6 a.m.
5. Loss of appetite and does not relish her food.
6. Loss of interest to do anything.
7. Has spells of crying for no apparent reason and she feels helpless and worthless.
8. Has become irritable of late.

No. of doctors who wrote.

Correct diagnosis (Depression)	Chose Antidep. drug	Dose 50-75 mg/day	Side effects Antichol. effects	Duration of Treatment 3-6 months
71	55	41	26	34
(53.8%)	(41.6%)	(31%)	(19.7%)	(25.7%)

TABLE 6

CLINICAL HISTORY No. A. 6.

1. 20 years old male college student.
2. Brought by hostel mates.
3. Duration of symptoms : one month.
4. Unprovoked anger, and at times physically violent.
5. Accuses his room mates of trying to poison him.
6. He complains that his thoughts are automatically being broadcast on radio.
7. His friends have noticed that since about one year he is becoming more and more withdrawn and uncommunicative. No bad habits like drug abuse.

No. of doctors who wrote.

Diagnosis (Schizophrenia)	Chose CPZ	Dose 200-400 mg/day	Treatment Duration 1-2 Years
74	69	48	39
(56%)	(52.3%)	(36.4%)	(29.5%)

COMMENTS ON PRE-TRAINING ASSESSMENT

Doctor's responses to clinical stories clearly show that their knowledge and skills regarding the management of mental disorders are very inadequate. Though they (88.6%) could make a diagnosis and chose the correct drug in the case of epilepsy (Clinical history A 1) only 60% mentioned the common side effect like drowsiness and 40% knew the correct line of management of this side effect. 55% of them were not sure of giving the drug for 5 years after the last fit.

On the average 50% of them could make a diagnosis of hysteria of neurosis regarding clinical history A2 and A3. They were not clear about the management of these cases i.e., whether a drug is needed or not, whether to prescribe minor tranquilizer or not and how long that drug to be given etc.

Only 34% made a diagnosis of mania (clinical history A4) 53.8% made a diagnosis of depression and 56% made the diagnosis of schizophrenia. But their understanding regarding chosing antipsychotic drug, or antidepressant drug, their dosage and duration of treatment was very inadequate.

Many of them openly accepted that their knowledge in this regard was limited because they did not get any training or got inadequate training during their undergraduate education. They also said that they did not make an effort to manage these cases because they always tried to refer these cases to specialists. They also reported that they had an idea that management of mental disoaders was beyond their capacity and resources. As a result of this, they left many questions un-answered. They wrote incomplete and or even strange answers like : for diagnosis—mental syndrome. Hallucinatory or delusion syndrome, hysterical depression, psycho depression, malinerging psychosis, etc. Drugs—prescribing Phenobarbitone to psychiatric cases. Chlorpromazine in 10 mg. or 25 mg. dose for psychosis. Diazepam tablets to psychotic cases. Most of them did not mention the common side effects.

Duration—starting from a few days to life long.

Most of them did not fill up the column on 'what specific advice to be given to the patients and their family members'.

Most of them were not sure of what would happen to the patient after 6 months of treatment.

All these issues were made note of and discussed during the training sessions.

Pre-training assessment clearly indicates the strong need to strengthen and improve the under-graduate training in psychiatry for doctors.

Post Training Assessment of Doctors

TABLE 1

CLINICAL HISTORY No. B. 1.

1. 15 years old girl, comes with mother.
2. Duration of symptoms — 4 months.
3. Since 4 months had 7 attacks of suddenly becoming unconscious for 1/4 hour or so.
4. While she was standing, on two such attacks, she had fallen and sustained injuries.
5. After getting up from the attack she complained of headache for a day.
6. During a few attacks, she had bitten her tongue.
7. All the 4 limbs, are reported to shake during the attacks.

Out of 94 doctors. number or doctors who wrote.

Correct Diagnosis (Epilepsy)	Chose Pheno-barbitone	Prescribed 60 mg hs.	Mentioned side effects Drowsiness.	Advised bed time dose + Reassurance	Duration of Treatment as 5 years after the last fits
92 (97.9%)	92 (97.9%)	88 (93.6%)	84 (89.4%)	78 (83%)	84 (89.4%)

TABLE 2

CLINICAL HISTORY No. B. 2.

1. 20 years old girl.
2. 2 year back, got married to a boy whom she did not like.
3. Since one year, often she is getting headache and always complains of weakness, lack of appetite.
4. 4 months back, when her husband scolded her she fell unconscious and was said to be possessed by a spirit.
5. Now she is in her parents house and refuses to go to the husband's house. There, she is symptom free.

No of doctors, who wrote.

Correct Diagnosis (Hysteria)	No Drug/Placebo	Minor Tranq like Diazepam 5 mg–10 mg a day
86 (91.5%)	65 (69.1%)	24 (25.5%)

TABLE 3

CLINICAL HISTORY No. B. 3.

1. 25 years old factory worker.
2. One year back, he got chest pain while working and immediately went to the factory doctor.
3. After examination, the doctor said 'nothing wrong' and gave him some tablets.
4. Being not convinced he consulted, heart specialist who also told him that his heart was in good condition.
5. But he continues to have chest pain, increased heart beat, weakness. He thinks that doctors have failed to detect the nature of illness. Worries about his health and the future of his family. He does not work well. He does not get good sleep.
6. His father had died due to heart attack one year back.

No. of doctors (Out of 94) who wrote.

Correct diagnosis (Neurosis)	Prescribed minor Tranquilizers like Diazepam sung — 10 mg.	Duration of Treatment < 2 months	Duration of Treatment > 2 months
85 (90.4%)	82 (87.2%)	21 (22.3%)	36 (38.2%)

TABLE 4

CLINICAL HISTORY No. B. 4.

1. 36 years old villager, works as an agricultural labourer.
2. From 3 months he talks too much. He says that he is a land lord and claims to have lot of money.
3. He does not do any work, wanders in the village, talks to everybody uncecessarily.
4. Of late he is very irritable, scolds people for not taking his advices. A week back he picked up a quarrel with his neighbour, for no good reason.
5. He abuses his wife with the reason that the food she serves is not tasty, though others say that she cooks well. His sleep is disturbed.
6. He had a similar episode 2 years back and recovered totally within 4 months.

No. of doctors (Out of 94) who wrote.

Correct Diagnosis (Mania)	Chose CPZ	Other Anti-Psychotic drug	Dose of CPZ as 200-400 mg.	Side effects EPS. and Anti-chol Eff.	Antipark-drug (THP)	Duration Treatment as 3-6 months.
89 (94.7%)	88 (93.6%)	—	88 (93.6%)	83 (88.3%)	63 (67%)	58 (72.3%)

TABLE 5

CLINICAL HISTORY No. B. 5.

1. 45 years old lady.
2. She attained menopause 2 years ago before which she had irregular menstruation for one year.
3. Since $2\frac{1}{2}$ years she is dull, showing less and less interest in daily activities. She complains of weakness, headache, pain in the waist and often seeks medical consultation.
4. Now-a-days she weeps and says that is better to die.
5. At times she loses temper and accuses her sons that they are neglecting her. But others know that her children like her very much.

No. of doctors who wrote.

Correct Diagnosis (Depression)	Chose Anti-dep Drug	Dose 50–75 mg.	Side-effects Anti chol. effect.	Duration of Treatment 3-6 months
90	86	78	66	76
(95.7%)	(91.5%)	(83%)	(70.2%)	(80.8%)

TABLE 6

CLINICAL HISTORY No. B. 6.

1. 17 years old girl, S.S.L.C. student.
2. She got first class in 8th standard but later she is getting lower marks in the examinations. Teachers do not know why this is happening.
3. Now-a-days she does not mix with others and prefers to be alone,
4. She believes that others talk ill of her, but everybody know that it is not so.
5. At times, she talks and laughs to self for no known reasons.
6. At times she behaves in such a way that others get embarrassed and fail to understand her.

No. of doctors who wrote.

Diagnosis Schizophrenia	Chose CPZ	Dose 200–400 mg/day	Treatment duration 1–2 years
89	86	81	67
(94.7%)	(91.5%)	(86 2%)	(71.3%)

Comments Regarding Post-Training Assessment

There is a remarkable improvement in their performance. They were confident of the answers they had written. Their diagnostic ability improved significantly (case histories B 1 to B 6 — 92% – 86% –85% – 89% — 90% –89% in that order). They were able to chose the correct drug for epilepsy, neurosis, mania, depression and schizophrenia (88%, 82%, 88%, 86%, 86%) and they know the correct dose and their common side effects. But nearly 25-35% of them were not sure of the duration of treatment. Any way decision about duration of treatment in hysteria, neurosis, schizophenia is a difficult task even for specialists.

The wrong answers and the doubts were discussed with the trainees in the last session of the training course.

Thus the difference between pre - and post-training assessment was a clear indication of the doctors ability to learn these things in a short period. It helped the trainers to make modifications in the contents and methods of the training course so that the objectives of the course were achieved.

Pre-Training Assessment of knowledge and attitude of Health Workers

TABLE 1

The items which elicited wrong answer by many health workers

Item	Total No. of respondents	No. of respondents who gave *wrong* answers	%
1. Masturbation, semen loss produce nervous weakness	533	294	55
2. Mental patients are always dangerous	533	199	37.3
3. Masturbation, semen loss or excessive sex cause mental illness	533	193	36.2
4. Mental patients can be treated in your local hospital	533	219	41
5. Marriage can cure mental illness	533	172	32.3
6. It is safe to keep the mentally ill persons inside the mental hospital	141	193	80

7.	Mental Retardation is a type of physical or mental illness	241	184	76.3
8.	Pregnancy after the age of 35 increases the risk of mental retardation in the child	241	123	51
9.	Tonics and injections are to be given to improve the intelligence of MR children	287	116	40.4
10.	Difficult labour can lead to mental retardation in the child	241	115	47.7
11.	It is better to admit the child into a hospital or an institute	241	141	58.5
12.	One should hold the limbs of an epileptic patient to minimise convulsions during an attack	287	157	54.7
13.	He should be turned to a side	287	124	43.2
14.	To facilitate early recovery give drinks (water/coffee) to unconscious patients	287	131	45.6

Post-training Assessment of Health Workers

TABLE 2

The items which elicited wrong answers during *post-training* assessment

		Total No. of Respondents	No. of resp. who gave wrong answers	%
1.	Masturbation, semen loss produce weakness, memory loss and impotence.	457	166	36.3
2.	Mental Patients are always dangerous.	457	79	17 3
3.	Mental Retardation is a type of physical or mental illness.	257	108	42.0
4.	It is safe to keep mentally ill inside the mental hospital.	257	94	36.5
5.	Masturbation, semen loss, excessive sex cause mental illness.	257	84	32.7
6.	Whatever you do, mentally retarded child will not improve.	257	60	23.3

CHAPTER 9

LONG TERM EDUCATION

The three attempts to evaluate the mental health care activities of trained PHC personnel, by random surprise visits by the expert team, though served its purpose, cannot be a feasible method as it would require heavy inputs in terms of money and manpower to cover all personnel and agencies. A need of developing a simple and effective method to evaluate the programme, made the unit to organize 'one day refresher cum review meetings' at one or more than one centre in a district. The State programme officer for mental health suggested that all the trained doctors and health workers, district health administrators and two faculty members from NIMHANS would take part in these meetings and review the programme. TA/DA of the doctors would be met by NIMHANS whereas that of health workers by state department. Every effort to make district administrators (Zilla Parishats) to participate in these meetings was to be made by the department. This was a desirable as well as essential need as Health Care services come under the purview of Zilla Parishats in Karnataka. A programme was worked out to conduct these review meetings – one round for doctors and later another one for health workers separately. The aims and objectives were :

1. To get feedback from trained PHC personnel about their mental health care activities done after undergoing training.
2. To understand the difficulties and problems encountered – both technical and administrative by them in the clinic and in the community.
3. To sensitive district – health as well as general administrators regarding their role in organizing better mental health care services.
4. To conduct a refresher training so as to clear their doubts and give necessary additional information.

A proforma (Appendix–18) was designed to get the feedback regarding –

a) Number and types of cases managed
b) Number and types of cases referred
c) Availability of essential psychiatric drugs
d) Specific difficulties in the management

e) Maintaining records

f) Involving paramedical staff

g) Monitoring

h) Mental health education

i) Usefulness of the training programme.

Such meeting were arranged at Mysore, Madikeri, Hassan, Mangalore, Mandya, Munirabad, Raichur, Bheemarayan gudi, and Gulbarga during the months of August, September, October and November 1987. The trained doctors and health workers of 8 districts were expected to attend. These meetings were attended by :

1) State Programme Officer of Mental Health.
2) Divisional Joint Director of Health & F.W. of the respective division.
3) District Health Officer of the respective Districts.
4) Three to four Assistant District Health Officers of the respective districts.
5) Representatives of Zilla Parishats.
6) Director of NIMHANS or Head of the Dept. of Psychiatry, NIMHANS.
7) One faculty member of the CMHU of Dept. of Psychiatry, NIMHANS.
8) Trained Personnel.

TABLE 1

District	Total Number of Doctors trained from 1982 to July 1987	Number of trained doctors working in the district (Others have moved out)	Number of doctors who attended the meeting	%
Mysore	19	10	10	100
Kodagu	20	17	6	35
Hassan	33	30	26	86.6
D. K.	17	16	15	93 7
Mandya	43	29	28	96.5
Raichur	62	38	31	81.0
Gulbarga	53	41	29	70.0
Bidar	16	12	9	75.0
	263	193	154	80.0

The meetings generally started by 10.30 or 11 A.M. and continued up to 6.30 or 7 PM. In the beginning, they were told about objectives of the meeting and were asked to fill up the proforma. Later each doctor was asked to present his work and difficulties openly. Others were allowed to ask questions and clarify the information given

by the presentor. In some places, some doctors had brought one or two difficult cases for consultation which were used to demonstrate to the whole group. It was felt that most of the doctors did not overreport but under-reported as far as the number of cases they had managed. When they discussed a few cases, they used to suddenly remember a few more cases they had treated. This is because they had not maintained records and were reporting by memory.

Thus the total number of cases seen by 154 trained doctors were as follows :

TABLE 2

Trained from	Total Cases	No. of doctors	Average number of cases per doctor
Mysore (Aug. 1984)	153	10	15
Mandya (Aug. 1984)	572	28	20
Kodagu (Oct. 1984)	109	6	18
Hassan (Feb. 1985)	384	26	15
D. K. (March 1985)	953	15	25
Raichur (Apr. 1982)	803	31	26
Gulbarga (Apr. 1982)	400	29	14
Bidar (Apr. 1982)	124	9	14
TOTAL	2898	154	19

TABLE 3

Diagnostic break-up of cases

Schizophrenia	204	7%
Mania	47	1.6%
Depression	213	7.3%
Other Psychoses	49	1.7%
Neuroses	784	27%
Mental Retardation	186	6.4%
Epilepsy	1414	49%
	2898	100%

TABLE 4

Availability of free drugs (out of 154 centres)

1.	CZP Tab	77	50%
2.	CPZ Injection	22	14%
3.	Diazepam Tab. 5 mg.	133	86%
4.	Diazapam Injection	71	46%
5.	Phenobarb 30 or 60 mg. Tab.	103	67%
6.	Imipramine (Antidep.)	Nil	0
7.	Fluphenozine Deconoate Injection	Nil	0
8.	THP (Anti-parkin drug)	Nil	0

TABLE 5

Numbre of cases referred to specialist centre

79 doctors had reported of referring difficult cases (ranging from 1 to 10) to the specialists or to bigger hospital either because of diagnostic problem or management problem. Further details of such cases could not be obtained because of lack of time and also the incomplete picture of the problems.

TABLE 6

The types of emergency cases treated by about 22% the doctors are :

1. Acute Functional Psychosis/Excitement.
2. Status epilepticus or cluster attacks.
3. Drug over-dosage either accidental or suicidal.
4. Hysterical Reactions.
5. Organic Psychosis.

TABLE 7

30% doctors mentioned that they had maintained some records for the patients. But on enquiry, it was observed that they had made recording in their usual registers and the necessary details were not available.

TABLE 8

66% doctors mentioned that they discussed mental health care programme in the monthly meetings. But they did not conduct any organized training. Thus they themselves reported that health workers involvement in the programme was very inadequate.

TABLE 9

42% doctors reported of conducting mental health education either as part of Orientation Training camps for village leaders or separately.

Some of the interesting problems and cases brought for discussion during the meeting, were as follows :

1) Two psychotic patients developing pitting oedema in the face and limbs after taking CPZ 400 mg. a day. Oedema disappeared with changing the drug to Haloperidol.

2) A case of hysteria where an adult developing severe pain in the (R) side of the face, and limbs and becoming highly irritable and unmanageable after an experience of seeing 'a ghost' in the grave-yard. He did not respond to treatment in the hospital but recovered completely with faith healing.

3) A girl developing attacks of headache, staring look, incontinence of urine ; in between she was alright. Other times she used to develop oedema in the limbs. He advised her to be taken to a major hospital. But the girl expired suddenly.

4) One doctor wanted to know whether institutional care to grown up mentally retarded individual was better, and how to manage an epileptic child whose attacks were not controlled with Phenobarb and developed stiffness of the limbs.

5) A case of hysterical fits, not willing to accept the diagnosis and going to different doctors claiming that he is an epileptic and asking for drugs.

6) Why and how lithium was prescribed by a private psychiatrist to a case of schizophrenia of 4 years duration. What are the conditions which get benefited by Lithium Therapy.

7) How to counsel a 40-year old man regarding his psychogenic impotence, who expects a drug for his problem ?

8) A case who was diganosed by specialists in Mental Health Camp held at Murnad, Kodagu and being treated as a chronic schizophrenia. Post martum was done as it was considered to be an un-natural death and revealed huge frontal lobe tumor.

9) A case of 60 years old person being a chronic alcoholic, developed involuntary movements of the lips and angle of the mouth after touching 'a patient with cancer who died later'. Are these movements psychogenic or organic ?

10) A lady aged 50 years repeatedly coming to the centre with the complaints of 'worms crawling sensation' on her scalp. No other psychotic features. She improves for a short period with B complex injection. She lives alone.

11) A 30-year old male developing suspicion, sleeplessness and abnormal behaviour of 2 days duration and abnormal behaviour of 2 days, no precipitating factor. Though he was on CPZ 450 mg. that morning there was an exacerbation of his suspicious ideas. He was drowsy most of the time. The doctor did not know whether he should increase/decrease the dose of CPZ.

12) 38-year old male a known epileptic and was on Gardenal 60 mg. and DPH 100 mg. The last attack was 2 months back but was complaining 'attacks of weakness'. On enquiry the description of these attacks were as follows. He would get fear, weakness all over the body and altered sensorium which would last for 2-3 minutes. They were 'abortive attacks'.

13) An adult male having attacks of hearing voices, beating the table for 2-3 minutes. After the attacks he would be dull for the entire day. He was getting such attacks once in 2-4 weeks. He was treated as a case of psychosis. The group made a diagnosis of Temporal Lobe Epilepsy and suggested that he should be put on Anti-epileptic medication.

14) A judge going regularly to a 'peer' for relief as he was suffering from burning sensation on the buttocks whenever he would sit on his chair in the court. He had refused to consult the doctor.

15) 70-year old man developing abnormal behaviour, repeating words like a parrot, wandering aimlessly from one year. The doctor wanted to know whether this was a case of schizophrenia of Dementia.

16) An adolescent male, known epileptic, fits are not under control. Now he is having attacks of transient loss of vision lasting for an hour.

17) A person was brought and claimed that he developed "Mental illness" immediately after he giving evidence in a court of law. They wanted a 'Certificate' from the doctor that he was mentally ill. Legal problems associated with issuing certificates to mentally ill were discussed.

18) 22 year old male, had two attacks of convulsions, had one in front of the doctor who made a diagnosis of "Hysterial fits". This patient had made an attempt to commit suicide 6 months ago. He was referred to NIMHANS where he stayed for 20 days. He was put on Antiepileptic medication. One week after discharge, he was brought dead as he had consumed organo-phosphorous compound. Doctor wanted to know the correct diagnosis.

19) 17 year old boy being irregularly treated for Major Epilepsy, now having attacks where in

a) He develops fear/palpitation for a minute.
b) Then he remains in altered sensorium.
c) Sometimes develops pain abdomen during such attacks.
d) Remains dull or exhausted for 10 minutes.

Whether these symptoms were psychogenic or part of epileptic attacks.

20) An employee of the guest house, going to many doctors with pain abdomen, weakness, sleeplessness. But later the local doctor suspecting whether this could be a case of depression, got him examined by a psychiatrist. He put him on anti-depressant drugs. There was 50% improvement.

21) Steriod-induced psychosis : Patient was an asthmatic and was better only with steroids. He developed psychosis. By stopping steroids, psychosis disappeared but asthmatic attacks became severe. Doctor wanted to know what to do in this case.

22) A child with petitmal seizures initially responding to Zerontin but later developing major seizures also. The child is deteriorating but the parents no willing to continue the treatment, possibility of SSPE was thought of.

23) 25 year old male, known case of migraine headache, complaining constriction sensation in the chest, cannot breathe and remains paralysed for 2-3 months during sleep.

24) Cycloserin induced psychosis in a patient who was suffering from tuberculosis.

25) A lady developing hysterical neurosis (abnormal talk, later remaining silent and non-responsive) because she was worried about the safety of Rs. 1,000/- her savings. When the doctor got the money for her through her husband.

26) An adult male developing psychosis fourth day after his marriage. Family members with the advice of a healer, starved him and poured cold water on his head 3-4 times daily. One week later, patient became unconscious when PHC doctor was called to attend him. But patient died on the same day.

General Observations

Out of 225 doctors trained, 193 doctors were called to attend the meetings. 154 doctors attended. Thus the attendance (80%) is satisfactory. Almost all of them had initiated mental health care activities in their centres and on the average each one had seen and tried to manage 19 cases (rangs being 1 to 120 cases). Nobody felt that it was an extra or additional burden to treat mentally ill. On the other hand, they were eager to treat these cases as it would increase their credibility in that community. Many of them reported that they recognise the multiple somatic complaints and frequent visits of women after tubectomy as 'Neuroses' arising out of various psycho-social factors and they were

trying to counsel them in a better way than what they were doing earlier. Their approach to the patients with any type of ailments had changed for the good. They were no more scared or puzzled by psychotic cases. They were able to diagnose and plan the management. Each doctor had difficulties in an average one to three cases and had referred them to the specialists. They reported that they were managing the cases of epilepsy on a more scientific basis and could effectively control the attacks. Most of them had interesting cases, a typical cases and shared their experiences with others.

The common problems reported by them are :

1) *No or inadequate supply of drugs* : 50% of the doctors reported that CPZ tabs were available, but in inadequate and low strength (like 10 mg. or 25 mg. instead of 50 or 100 mg.)

   67% doctors had phenobarbitone 30 or 60 mg strength in inadequate quantity like 1000 or 2000 tabs per year which is sufficient to treat 3 or 5 patients only. Many of them had complaints regarding the quality of these tablets. Diazepam tablets were available with 86% of the doctors. But injectable CPZ and Diazepam were available in a few centres only. None of the doctors had anti-depressant drug (like Imipramine Tab) anti parkinsosian drug (like THP) and Depot Phenothazine injection (Fluphenazine Deconoate) which is convenient in treating in chronic psychosis).

2) *Ignorance, misconceptions of people* regarding the causes and management of mental disorders and epilepsy.

   People are found to be having more faith in traditional healers than PHC doctors in managing these cases. They are not aware of the mental health care facilities at PHC. A few doctors only had put up boards in this regard in their centres and tried to educate people during orientation training camps.

3) *PHC and PHU's (Government) medical and non-medical personnel having low-credibility in the community* · Because of various reasons, people are not having confidence regarding the quality of care available through this system. This view has not approved by some.

4) *No administrative support and monitoring of the programme* : Mental Health Care programme was not discussed and reviewed as a routine in monthly conferences at PHC, taluk or district administrative agencies, like DHO, DC or Zilla Parishads etc.

5) *Non-availability of records* and other stationary materials for smooth and meaningful maintenance of records for the patients.

6) *People not willing for long-term care* and expecting quick, and dramatic cure, resulting in poor or irregular or no follow-up in a sizable number of patients.

7) *As a few health workers* (One to six) *only are trained in* mental health care, the remaining staff are ignorant of the programmes. The trained doctors expressed their inability as well as unsuitability in training their own workers in mental health programme. Thus involvement of para-medical staff was very limited.

8) *Slow improvement or failure to get the expected improvement* and relapses in certain cases of epilepsy and psychoses.

The common topics on which many doctors wanted refresher training were :

1) Diagnosis and management of organic psychosis.
2) Diagnosis and management of hysteria.
3) Management of febrile fits.
4) How to adjust the drug dosage in epilepsy.
5) Legal aspects of issuing medical certificates to mentally ill.
6) Clinical differentiation between withdrawn schizophrenia and endogenous depression.
7) How to counsel a neurotic patient.
8) Management of mental retardation.

Suggestions which came up during discussion

1. Regular supply of essential drugs like CPZ, Imipramine, THP, Phenobarb of good quality by (a) using 40% discretory funds of DHO, and (b) requesting GMS to include these drugs in package indents, (c) quality drugs can be purchased from NIMHANS Consumers' Co-operative Society.

2. De-centralised training to all the paramedical staff at taluk or PHC levels (two or three days duration). The training is conducted by Mental Health experts either from NIMHANS, State Service or by interested trained doctors.

3. Orientation training to all the supervisory staff of the department (including DHO and ADHOs) either at NIMHANS or at Divisional level by NIMHANS experts.

4. Review of the programme in the monthly meetings at PHC and DHO with proper recording and reporting system. The report should reach DJD Programme Officer of mental health, DHS and NIMHANS regularly.

5. The trained doctors should develop contact with nearby psychiatrists of NIMHANS either personally meeting them or through letters so that they can discuss problem cases and get guided in managing them. If Possible, district psychiatrists should go to PHCs once in a particular period to give consultation

6. Mental Health Education should become part of Orientation Training Camps organised at village level. Other traditional methods and medias should be used to increase the awareness of people. District Health Education Officer and his staff should take active part in this regard.

7 'Manasika Arogya' bimonthly bulletin published from NIMHANS can be an effective vehicle for continuation of education for PHC personnel.

8. Deputation of doctors from each district should be more organized and regular so that in a short period, there will be one trained doctor in every institution.

9. There is a need to conduct such Refresher-cum-Review meetings once in 6 months or at least once in a year at district headquarters for 1 day or preferably for 2 days. Reading materials should be given to the doctors.

10. In patient (minimum of 20 beds) facilities and ECT should be made available at District General Hospitals, where specialist's services are a must.

Simple record sheets (20 sheets booklet) were given to all the doctors of 8 districts. Revised Monthly return forms (Appendix 19) were given to Bidar, Gulbarga and Raichur Districts doctors with a request that they should send monthly returns to DHO and NIMHANS. The feedback will help to further simplify the record system. Every participant received the book 'Samajika Nambikegalu mathu Manasika Arogya' (Social beliefs and mental health) which covers people's beliefs and practices towards mental disorders. They were requested to circulate the book among all the staff of PHC.

Refresher–cum–Review Meetings of Health Workers

One-day refresher-cum-review meetings were organised for the trained health workers of Bidar, Gulbarga and Raichur districts at Bidar, Yadgir, Gulbarga, Raichur, Sindhanur and Gangavathi during November 1987. The Divisional Joint Director, District Health Officer, Assistant District Health Officers, trained doctors, two staff members from community mental health unit of NIMHANS took part in these meetings. A specially designed proforma (Appendix 20) was administered to the health workers who were asked to give the information regarding :

a) Number of cases they identified
b) Number of cases they referred and followed
c) Availability of free drugs
d) Support they have from doctors and supervisory staff
e) Mental health education
f) Difficulties encountered in the community.

Each worker was administered with another questionnaire (Appendix 21) to check their knowledge regarding mental health care. Each worker was asked to present his work in the meeting. Some of the workers had bought cases for consultation which were discussed in the group.

District	Total number of workers trained from 1982 till September 1987	Total number of workers still working in the district	No. of workers who attended the meeting
Bidar	32	26	14
Gulbarga	91	Figures not available	28
Raichur	111	—do—	77
			119

After reviewing the work of 119 health workers of 3 districts, the following findings are worth considering.

Total No. of cases identified by them :

Psychoses and Neurosis	276
M. R.	161
Epilepsy	279
	716

On the average, each worker had identified 6 cases over a period of a few months to five years. Irrespective of which he/she was trained recently or long back, the number is almost same. On inquiry, it was found out that most of them had not looked for cases, actively in their area ; they have made note of most visible cases which they happened to see and have tried to refer. They have failed more often than succeeding in convincing people to go to PHC for mental health care. Their ability to do the follow up is also limited. They claim that they are educating the people.

* They do not look at Medical Officers as the source of support and encouragement. They do not discuss the problems as they know that it is futile exercise. They are angry because some doctors take money for the services rendered at PHC and ignore the workers.

* They are totally pre-occupied with family planning programme. The targets, the pressure from both the department and people have reduced their morale. They feel that they are let down by everybody.

* People refuse to go to PHC where free treatment is not available. They blame for not getting free drugs for getting poor quality drugs in inadequate quantity.

* In each PHC, one to six workers are trained. The remaining 25 to 30 workers, the supervisory staff and others are not trained. One doctor out of three might have been trained or not. The programme is not discussed in the monthly meeting. Lion's share of the discussion is reserved for family planning. Thus the workers say that there is no encouragement, reminders to do mental health work and no opportunities to clarify doubts. Thus they have not actively persued the mental health programme.

* They did not know, how they could contribute to mental health programme during their routine activities like immunization, antenatal care, family welfare programme etc.

* When the patients did not show improvement with treatment most of the workers did not know what to do and how to explain it to the family members. They gave up the case or people stopped consulting them.

* Severely ill psychotics posed a specific problem to the workers. They did not know how to make them to accept drugs.

* Doctors almost always told the workers to get the case to the hospital. No home visits made by the doctors. If they had done it, it would have increased the credibility of the worker (as well as the doctors) in the community.

* Most of the workers had retained the following messages :
  1. Mental illnesses, epilepsy are treatable
  2. First aid in epilepsy : Do's and Dont's
  3. No drugs for mental retardation
  4. Long term, regular medication is needed for psychoses & epilepsy
  5. They knew the names of CPZ, Phenobarb and their initial/average dose.
  6. They remembered one to three common side effects but did not know clearly the management of these side effects.

Some of the cases brought for consultation which were demonstrated to all the workers are :

1. Atypical grief reaction of 3 years duration (lady with depression after losing her son by drowning).
2. Hysterical fits (demonstrated) in a girl of 13 years old who used to get major epilepsy earlier.
3. Trigeminal Neuralgia.
4. Many cases of epilepsy not responding to medication.
5. A few cases of mental retardation.
6. Hyperkinesis with M.B.D. in a girl of 6 years old.

7. Cases of chronic schizophrenia etc.
8. One epileptic who was fit free for 4 years with medication but had an attack a week ago. (Precipitating factor : he kept himself awake up to 1.00 A.M. on 2 days).
9. A lady aged about 40 years, complaining of beating sensation on the vertex, palpitation, being dull, withdrawn, demanding X-ray examination of the head and abdomen, sleepless etc., of 6 months duration (Endogenous depression).
10. An adolescent boy with epilepsy and abnormal behaviour.
11. An old man who was having II episode of being dull, talking about suicide, not working, being irritable for 1 month duration. He had an attack of epilepsy 10 years ago. I episode of mental illness occurred one year and lasted for 2 months.
12. Hysterial hiccough in a young girl of one month duration.
13. 4 attacks of hysterical fits in a young girl and now symptom free for the last 20 days.
14. Early features of schizophrenia in a young boy of 26 years old.
15. Acute psychotic episode of 10 days duration in a young female. Marriage proposal was a precipitating factor.
16. A lady aged about 40 years, wife of the driver in DHO's office developing psychotic behaviour 40th day after delivery and being continuously ill for the last 5 years. She is suspicious, abusive, irregular in household chores and not allowing anybody to come to her house. House visit was made and treatment was started.
17. Girl aged 20 years being psychotically ill for the last 3 years, taken to local psychiatrist and then to NIMHANS where she stayed for 3 months. She received drugs and ECT but did not improve. Family members lost faith and brought her back. Since last one week she had become very aggressive, unmanageable. Drugs were prescribed.
18. Adult male aged 25 years, became withdrawn, dull not bothering about personal needs and work from last 10 years. He was admitted in Dharwad Mental Hospital for 2 months and sent back without any improvement. Now-a-days he has stopped talking, does not sleep. He does some minimal work on instructions, smokes excessively.
19. Boy aged 17 years, son of Sr. Health Inspector of Parhatabad PHC of 6 years, developed fever, became unconscious for 3 days. Recovered with deficits like a right side hemiplegia, poor memory, less intelligence. He is in 10th standard but does not know any thing, even simple additions, substractions.
20. One worker reported how he managed a case of an adult male who used to behave oddly by spitting frequently and not relating to people properly. He

used to tell the worker that he did not get any respect from his wife and family members who used to criticize him for not earning. He was complaining weakness, lack of ideas and dejection. The health worker started counselling him every day for 30 minutes, encouraging him to be bold. He gave him 0.5 ml, of B.C. twice a week. The patient has recovered and now working in Bangalore. He sends Rs. 300/- every month to his family.

21. A female worker reported that she successfully persuaded a girl who came back from her in-laws house immediately after the marriage to go back to her husband. She was afraid of the husband but did not reveal the reasons. The health workers told her a story of a girl who suffered a lot because of her hasty decision to live in her mother's house, leaving her husband. This helped.

22. Another female worker told about a case of mentally retarded girl who got married and had to undergo M.T.P. as she was unable to look after herself. Parents had made a request for tubectomy but the worker thought it was not possible. The case was discussed.

23. A female worker who lives alone (Parents are in Bijapur) had an episode of depression. Consulted a private psychiatrist at Bijapur and was an antidepressant drugs for the last 2 months. She presented her own problems and discussed.

24. One worker had identified a 12 years old boy with bedwetting of 6 months duration. The problem started after seeing a bear in the field. He takes only tea or other liquids.

25. A middle aged person, not taking meals for the last 40 years as he believes that because of Bhanamathi, he does not relish food. He takes only tea or other liquids.

26. 28 years old man who was alright 2 years ago, becomes dull, withdrawn, feels bored and sad for 2 days. He cannot do any work, sits/lies down. He recovers spontaneously. Last episode lasted for 12 days during which he started wandering in the streets aimlessly neglecting his personnel needs and hygiene. His sleep was totally disturbed. He had insight. He had recovered totally 2 days back.

Many workers had given proper first aid to persons when they had epileptic seizures.

Inferences

1. Though the trained workers have initiated mental health care work, and helped a few patients, they have not made an impact on the community.

   Training a few workers only from each PHC does not serve the purpose.

Expecting a few workers to support the mental health programme when majority of their colleagues and supervisors are not trained is un-realistic.

2. All the workers and their supervisory staff should be trained in a short period preferably nearer to their PHC.
3. Mental health programme has to be discussed and monitored every month during monthly conference at PHC.
4. Health workers have to be supplied with mental health education materials like posters, flash cards etc.
5. Once in 6 to 12 months, an intensive case detection week or fortnight has to be arranged.
6. Inter-personal relationship between the workers and medical staff should be improved.
7. A suitable incentive or award (other than cash) for the best work done by a worker in mental health care can be thought of.

Training in Mental Health Care for PHC Personnel in other parts of the Country

Both the Central Government and State Governments are taking interest in the implementation of National Mental Health Programme in a phased way. NIMHANS is conducting 4 weeks training programme called "**Training the Trainers of PHC Personnel in Mental Health Care**" for mental health professionals and teaching staff of training schools of health in the country. NIMHANS has also conducted one day or two day's workshop for health administrators and planners in the implementation of NMHP in their respective states. As a result of these activities, many centres in the country have started training programmes in mental health care for PHC personnel. Though the duration of training varies from centre to centre, the curriculum content, methodology, manuals and recording materials designed at NIMHANS are being used in the training programmes.

Following is the brief account of training activities of different centres, listed against the respective states and union territories.

ANDHRA PRADESH

* Training of PHC personnel of Shankarpalli PHC.
* Training of two batches of medical officers (Total 14) and 15 MPWs of Sangareddy District (1985).

BIHAR

* Training Programmes for PHC personnel and personnel of Mission Hospital at Ranchi.

DELHI

* Training of 91 doctors in 8 batches at Dr. Ram Manohar Lohia Hospital, New Delhi (1988).
* Training of 9 Medical Officers of Delhi Administration at Lady Harding Medical College, New Delhi (1987).

GOA

* Training of Junior Resident Doctors in Mental Health Care (on going).

HIMACHAL PRADESH

* Training of PHC doctors at Bhoranj of Hamirpur District (2 Batches) 1986.

KARNATAKA

* 31 PHC doctors of Dharwad District at Dharwad Mental Hospital are trained (1988).

KERALA

* Training of 29 Medical Officers (1986).

MAHARASHTRA

* District Nagpur is selected for implementation of NMHP.
* One week Training Programmes for PHC doctors in all the 4 mental hospitals (on going). More than 150 doctors are trained.

PONDICHERRY

* 25 doctors in 4 batches are trained (1987).

PUNJAB

* Training of 11 Medical Officers and 41 para-medical workers of Jandiala block of Amritsar District (1986).

RAJASTHAN

* Training of 16 PHC doctors and 79 health workers of PHC Jahota and Bichun.

TAMIL NADU

* Training for doctors of Mission Hospitals (on going)at C.M.C., Vellore.

UTTAR PRADESH

* Training of GPs at Lucknow (1987).
* Training of Medical Officers of Sitapur District (1987).

In certain Centers, evaluation of the work done by personnel was done jointly by NIMHANS and Department of Health & Family Welfare of the respective state or U T. The findings were almost same as those found in Karnataka. The similarities either in successes or in failures were striking.

CHAPTER 10

ISSUES RELATED TO TRAINING OF PHC PERSONNEL IN MENTAL HEALTH CARE

After training 353 doctors and 583 health workers in 95 batches, a number of issues have to be discussed in the background of experiences gained and the feedback from the trainees. There is also need to think of changes that are to be made to make the training programme more cost-effective so that it survives and progresses.

1) *Venue* : The training programme was conducted at Rural Mental Health Centre, Sakalawara, which is a part of Department of Psychiatry, NIMHANS. It was a centralized, residential programme. A team of 2 psychiatric social workers and 3 to 4 staff nurses were involved in the training. Outpatient clinics at Sakalawara, Anekal PHC, NIMHANS and NIMHANS wards provided case material for the trainess. Both the trainers and trainees could apply their mind without having other pressures in the training activities. In addition to these advantages, there are certain disadvantages like trainees had to travel long distances (like 600 to 700 km.) ; in some, they had to adjust to a different living set up and food, the expenditure involved (TA, DA) etc. It may not be possible for other states or centres to have such a rural based training centre. Other possible venues are :

a) Depts. of Psychiatry either in medical colleges or Dist. Hospitals.

b) Health and Family Welfare Training Schools.

c) Mental Hospitals.

d) Taluk Hospitals or Primary Health Centres.

Each venue has its own advantages and disadvantages. Depending upon the local resources, the venue has to be chosen. If a non-psychiatric set up is chosen as the venue like a PHC or Health & Family Welfare Training School, all efforts to be made to have live cases for demonstration and work up. During training, arranging mini mental health camps also can serve this purpose. Use of video recordings of the cases will be of help. In many places, weekly or monthly extension clinics are conducted by the psychiatric team. They should be utilized to train PHC personnel.

2) *Duration of Training* : Short duration training programmes have better acceptance by both administrators and the trainees ; they are less expensive and do not

disturb the 'service activity' to a large extent. But what should be the optimum period which equip the trainees with sufficient knowledge and skills to carry on the tasks assigned to them successfully ? In a centralised training programme 2 weeks appear to be an optimum period for the doctors. If the duration becomes less than that, the doctors may fail to develop confidence in treating psychosis cases. If one can increase the period to 20 days or so, the extra days should be made use of for working-up of cases only. Five or six days appear to be the optimum period to train the paramedical workers like health workers if one expects them to identify and follow-up psychotics, epileptics and mentally retarded.

If the training programme is decentralized and conducted in a phased manner *i.e.*, the trainees come back once or twice or more for further training inputs over a period of time than very short periods like two or three days training, repeated twice or thrice may also serve the purpose. (This is what is being done in District Mental Health Programme, Bellary).

3) *Content and Methods of Training* : A minimum of $\frac{1}{3}$ to $\frac{1}{2}$ the time should be allotted for practical training like

a) Case identification in the community or, O.P. clinics.

b) Case-demonstrations.

c) Work-up and discussion about diagnosis and management.

One has to work out the minimum number of cases of each diagnostic categories, to be demonstrated/discussed for the doctors and health workers, so as to help them to understand these disorders well.

In the present curriculum, alcohol and drug abuse, management of neuroses, practical demonstration of training of mentally retarded child are not given the due importance. This has to be considered seriously. Other topics which are relevant to a given geographical area have to be considered in planning the curriculum. The following methods are desirable in training :

a) Dialogue and discussion rather than didactic lectures.

b) Activity oriented sessions where the trainees have to do certain things themselves (like preparation of health education materials and teaching materials).

c) Role play.

d) Use of audio-visual aids (Charts are better than slides).

4) *Field Practice Area* : PHC personnel have to emotionally understand the advantages as well as practical difficulties of managing psychiatric patients close to the community. They should examine the patient in his own natural environment, how the

family members and others react to him and to his illness. This is possible only when there is a field practice area of the training centre. Mental health team should select an area either in the urban or rural set up (or in both), conduct service activities and have a pool of patients and their families for field of patients and their families for field training of PHC personnel. They can also demonstrate how to educate and involve the community in this work. The trainees are asked to duplicate this model in the areas of work.

5) *Pre-and Post Training Assessment :* The need to assess the trainees about their attitude and knowledge of mental disorders, before and after training is well known. But still standard assessment tools are not available for wider use. Though the case story method and multipurpose choice questionnaire designed by NIMHANS are serving the purpose, more simple and effective tools have to be designed on a priority basis or the present ones have to be improved further. The unit has further improved the tools and have standardized them (Appendix 22).

6) *Long Term Evaluation and Monitoring :* There is a strong need for built-in monitoring and evaluation of NMHP for reaching the desired targets (both quality and quantity wise). This should take place routinely in line with other already established National Health Programmes and through the existing monitoring system. Monitoring and evaluation takes place at different stages in the State Dept. of Health & Family Welfare. For example monthly review meetings are conducted by Medical Officer at PHC level, to whom all the para-medical staff report to similar monthly review meetings conducted at District Health and Family Welfare Office by WHO for all the administrative medical officers of PHC and General Hospitals. Bimonthly or quarterly meetings are held at divisional and state level. DHO's office receives the data from PHCs every month; processes it and sends it to state DHS's office where it is compiled, analysed and reported. Similarly Mental Health Care Programme has to be reviewed at PHC, DHO and DHS level under the direct or indirect guidance of mental health professionals.

Planned and Un-Planned visits to PHCs : Regular and pre-planned visits to PHCs can be made by the mental health professionals to personally verify the work done by PHC personnel. These visits can be unplanned and random also. During the visits, PHC personnel are interviewed ; their records are checked and patients who are being managed by them can be randomly examined. This will help to improve the quality of care given by them.

Periodic one or two days review meetings can be organized specially to review the mental health programme at least at district or divisional and state level in which all the concerned personnel participate.

Community indicators of mental health care to be selected and monitored. Very little work has been done in this area.

7) *Records and Reporting* : Record keeping and regular reporting is the backbone of a successful programme. Considering the time constraint and workload of PHC personnel, a simple recording and reporting system which contain the minimum essential informations have to be designed and standardized. Filing of such records should take only couple of minutes. NIMHANS has developed a single case record and report-form (Appendix 23) which is being used by PHC doctors and health workers. The reporting system has to be streamlined and the data has to be analysed periodically. Case finding, case holding and case cure rates can be worked out with such good recording system.

8) *Specialists Support* : A good referral system is very necessary to keep the interest and morale of PHC personnel in implementing of mental health care programme. Whenever the doctor gets doubts regarding diagnosis and management of cases, he should get the consultation of the specialists as earlier and as nearer as possible. Periodic visit of the specialist to PHC or PHC doctor having facilities to refer the patient to the specialist serve a useful purpose. Every district hospital for a general hospital with 100 beds, should have a mental health professional who can give such consultation to difficult consultation as well as inpatient facilities.

9) *Public Education Materials* : Mental health education materials to educate the public like posters, flash cards, folders, video or 16 mm films, booklets have to be prepared and made available free of cost or low price. NIMHANS has already designed and produced such materials. (They can be obtained by sending request to the Director, NIMHANS, Bangalore-29).

10) *Research Issues* : To improve the quality of the training programme, there is a need to have research activities carried by the training team, cost-effectiveness of the different methods of training has to be worked out. In addition to this qualities of care given by PHC personnel, its impact on the patients and their family members, on the community's attitude and knowledge about mental disorders and ill persons, on the mental health status of the people have to be worked out. Other areas of research which are related to training programme are carried out which help in improving the strategies to extend mental health care and quality of care given at different levels of health services. All the mental health professionals have to join hands and carry out research activities in the following areas :

1. Simple classification of mental disorders for PHC personnel with clear cut definitions and flow charts.
2. Drug management of psychoses, epilepsy, neurosis (concrete guide-lines regarding drug dosage, duration of medication).
3. Simple screening tools to identify neuroses and cost-effective methods of managing these cases.
4. Management-capsules for mental retardation, alcohol and drug dependence.

5. Cost effective methods of managing stress-related disorders and psychosomatic disorders.
6. Case identifications, case holding and case cure rates of PHC personnel regarding psychiatric disorders.
7. Incidence and natural course of the common mental disorders.
8. Prevailing psychosocial factors which contribute to the mental morbidity and how to control them.
9. Identification of socio-cultural factors which promote mental health and increase the quality of life.
10. Designing and developing mental health education materials.
11. Community indicators for mental health care etc.

Refresher Training Courses : Trained PHC personnel need periodic refresher training (once in one or two years). This has to be arranged either in the psychiatric centres or at district hospitals or any other suitable places. The curriculum of such refresher courses has to be decided on the evaluation of PHC personnel and the programme.

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Appendix I

COMMUNITY PSYCHIATRY UNIT

Name..... Date.....

Age..... Years of Experience.....

Education..... Centre/Subcentre.....

ATTITUDE QUESTIONNAIRE

I. Kindly read carefully the following statements. If you agree with the statement, put a tick mark against Yes, if you do not agree put a tick mark against No. There is no right or wrong in whatever your answer. Answer all questions.

		Yes	No
1.	Have you seen mad people ?		....
2.	Are you afraid of mad people ?		....
3.	If you were expected to look after a mental patient would you be scared ?		....
4.	Mad people act the way they do deliberately		....
5.	Mental illness is contagious		....
6.	Mental illness is hereditary		....
7.	Mental illness is incurable		....
8.	Black magic can cause mental illness		....
9.	Failure in love affair may lead to mental illness		....
10.	Death of a close relative may cause mental illness		....
11.	Financial problems can lead to mental illness		....
12.	Worries may lead to mental illness		....
13.	Unemployment may lead to mental illness		....
14.	Fright may lead to mental illness		....
15.	Physical and nervous weakness may lead to mental illness		....
16.	An excited patient should be confined to a room or tied up		....
17.	By beating, the mentally ill person can be taught to behave properly		....
18.	Do you know what fits are ?		....
19.	Fits are contagious		....
20.	Untreated fits may lead to mental illness		....

II. A list of possible causes of mental illness is given. Give them numbers 1 to 8 in the order of their importance.

a) Black magic
b) Failure in love-affairs
c) Death of a near relative
d) Financial difficulties
e) Worries
f) Unemployment
g) Fear of having seen something in the dark
h) Physical and nervous weakness

III. People adopt many methods to treat mental illnesses. The list is given below. Please put a tick mark against each item which you agree and recommend to others.

1. Marriage
2. Black-magic
3. Beating
4. Drug treatment
5. Ayurvedic drugs
6. Religions treatment (like going to temple, masjid, church)

IV. Similarly, there are many methods of treating epilepsy. Please put a tick mark against each item which you agree.

1. Drugs
2. Black magic
3. Marriage
4. Ayurvedic treatment
5. Beating
6. Branding
7. Religions rituals
8. Giving an iron object in hand

Appendix 2

COMMUNITY PSYCHIATRY UNIT
NIMHANS
BANGALORE

ATTITUDE QUESTIONNAIRE

Name..... Centre/Sub-centre.....

Age..... yrs. Education.....

Experience in years Date.....

NOTE : Read the following statements carefully and answer. Draw a circle around the correct answer. Eg. if your answer is yes, encircle the word Yes. Please answer every question.

Part 1

1.	Have you seen mental patients any time	Yes	No	Don't know
2.	Mental patients are always dangerous	Yes	No	Don't know
3.	Will you be scared of looking after a mental patient if you have to do so.	Yes	No	Don't know
4.	Mental patients behave the way they do deliberately.	Yes	No	Don't know
5.	Mental illness is contageous like small pox.	Yes	No	Don't know
6.	With proper treatment, mentally ill persons improve to a considerable extent.	Yes	No	Don't know
7.	Have you seen a patient with fits	Yes	No	Don't know
8.	Fits are contagious	Yes	No	Don't know
9.	Treatment with drugs, stops fits in almost all patients.	Yes	No	Don't know
10.	A person who is on treatment can attend to his daily tasks like going to school, work etc.	Yes	No	Don't know

Part 2

1. Mental illness can be caused by the following :

i) Separation, death, loss, quarrel & such other problems and difficulties	Yes	No	Don't know
ii) Head injury	Yes	No	Don't know
iii) Child birth	Yes	No	Don't know
iv) Too much drinking	Yes	No	Don't know
v) Severe fever	Yes	No	Don't know
vi) Untreated fits	Yes	No	Don't know
vii) Mentally ill person in the family	Yes	No	Don't know
viii) Masturbation/nocturnal emission	Yes	No	Don't know
ix) Evil spirits	Yes	No	Don't know

2. Treatment for mental illness :

i) Marriage	Yes	No	Don't know
ii) Exorcism/black magic	Yes	No	Don't know
iii) Beating and locking the patient in a room	Yes	No	Don't know
iv) Starvation	Yes	No	Don't know
v) Branding	Yes	No	Don't know
vi) Electric shock treatment	Yes	No	Don't know
vii) Drugs	Yes	No	Don't know

3. Treatment for epilepsy :

i) Branding	Yes	No	Don't know
ii) Keeping an iron object in the hands of the patient	Yes	No	Don't know
iii) Exorcism/black magic	Yes	No	Don't know
vi) Religious treatment (puja, holy dip, pilgrimage)	Yes	No	Don't know
v) Food restriction	Yes	No	Don't know
vi) Drugs	Yes	No	Don't know
vii) Marriage	Yes	No	Don't know

Please see whether you have answered all the questions.

Appendix 3

ASSESSMENT QUESTIONNAIRE TO DOCTORS

STRICTLY CONFIDENTIAL

1. In the last one month, approximately how many patients with psychiatric problems attended your clinic ? (Please, circle the answer nearest to your figure)

   (a) None
   (b) Less than 5
   (c) 6 to 10
   (d) 11 to 20
   (e) More than 20.

2. In the last 3 months have you referred any patient to a psychiatrist ? (Please circle the apropriate answer) YES/NO

3. If you have *NOT* referred a patient to a psychiatrist, what is the reason ?

4. In the last three months, appproximately how many new epileptics did you see in your clinic ? (Please circle the appropriate answer).

   (a) None
   (b) Less than 5
   (c) 6 to 10
   (d) 11 to 20
   (e) More than 20

5. Each of the following questions have alternative answers. Please choose the one which most approximates your belief and encircle it.

   (a) Do you think that mental disorders are serious illness ? YES/NO

   (b) Do you think that any normal person under stress can become mentally ill ? YES/NO

(c) Do you believe that mental disorders can be treated by spiritual or traditional faith healers. YES/NO

(d) If given a choice would you have chosen psychiatry as your career ? YES/NO

(e) Suppose, one of your close relatives develops some odd behaviour which you consider to be mental illness, would you discuss it with your friends ? YES/NO

6. In table 1 and 2 below are listed some possible factors which can be considered as causing mental illness and epilepsy respectively, please put a tick mark in the appropriate box according to whether you consider a factor important. Moderately important or not having any role at all.

TABLE 1

MENTAL ILLNESS

Factors	Important	Moderately important	No role
1. Heredity			
2. Witchcraft, black magic, modi, etc.			
3. Poverty			
4. Masturbation or excessive sex			
5. Excessive intelligence			
6. Over work			
7. Head injury			
8. Loss of loved one			
9. Lack of faith in God			
10. Contact with mentally ill			
11. Worries			
12. Body weakness			
13. Childhood experience			
14. Brain lesion			
15. Anything not covered above			

TABLE 2

EPILEPSY

Factors	Important	Moderately important	No role
1. Heredity			
2. Witchcraft, black magic, modi, etc.			
3. Poverty			
4. Masturbation or excessive sex			
5. Excessive intelligence			
6. Overwork			
7. Head injury			
8. Loss of loved one			
9. Lack of faith in God			
10. Contact with epileptics			
11. Worries			
12. Body weakness			
13. Childhood experience			
14. Brain lesion			
15. Anything not covered above			

7. Have you read any books on psychology or psychiatry ?
Please, circle the appropriate answer. YES/NO

If you have read any book, can you name one or two of them ?

8. Have you had any training in psychiatry ? Please, circle the appropriate answer.

(a) None

(b) Some, but unsatisfactory

(c) Adequate.

9. How important are the following factors to arrive at the diagnosis of mental illness ? Please put a tick mark in the appropriate box.

	Very important	Moderately important	Not important
1. E. E. G.			
2. Blood tests			
3. History from the eye-witness who has seen the attack			
4. History from the patient			
5. X-ray skull			

10. How important are the following factors to arrive at the diagnosis of epilepsy? Please put a tick mark in the appropriate box.

	Very important	Moderately important	Not important
1. E. E. G.			
2. Blood tests			
3. History from the eye-witness who has seen the attack			
4. History from the patient			
5. X-ray skull			

Dear doctor, please read the 6 case stories given and answer the questions for each story.

STORY – ONE

1. 21 years old male. Comes alone
2. Labourer
3. Duration of symptoms – 4 months
4. Sleeplessness
5. Irregular personal habits
6. At times talking or laughing to self
7. Expressing unfounded suspicious belief about others activities and intensions
8. He used to complain that his thoughts were being stolen by a particular neighbour.

STORY—TWO

1. 36 years old female, comes with son
2. Married housewife, with 4 children
3. Duration of symptoms—one month
4. Loss of sleep
5. Does not get sleep after 3 a.m. whereas previously she used to wake up at 5 a.m.
6. Loss of appetite
7. Loss of enthusiasm to do anything
8. Has spells of crying for no apparent reason
9. Has become irritable.

STORY—THREE

1. 13 years old boy, comes with parents
2. Student
3. Duration of symptoms—1 year
4. One year ago, soon after lying down to sleep, he screamed
5. He was then found to be unconscious
6. All his four limbs were held straight and jerking in rhythmic fashion.
7. He had passed urine while unconscious
8. He soon became alright
9. Had one more such attack 6 months ago, two more in the last 3 weeks.

STORY—FOUR

1. 40 years old married woman
2. Housewife, with two children
3. Duration of symptoms 6 years. The symptoms have become more disabling since 2 years.
4. Pain all over the body
5. Has consulted many surgeons and physicians, with many investigations, and medicines, without any appreciable change in symptoms.
6. She was married when 16 years old and soon gave birth to a son
7. The son ran away from home when he was 18 years old
8. Her daughter who is 20 yrs old now, was married away at the age of 18 yrs.
9. Ever since her daughter's marriage she had always felt that her husband does not care for and love her much.

STORY–FIVE

1. 10 yrs old girl, brought by mother
2. Student
3. Duration of symptoms–4 months
4. 4 months ago, when the mother got angry and shouted at her, patient fell down, and did not respond to mother's efforts to rouse her up
5. She shook her limbs
6. A few minutes later she got up and became alright
7. Since then she has this attack every time her mother becomes angry with her.

STORY—SIX

1. 26 yrs old male, comes with parents
2. Machine operator
3. Unmarried
4. Duration of symptoms for 6 months–2 yrs ago
5. While a young child, used to have unconsciousness and jerking of limbs during attacks of fever.
6. 2 yrs ago he became unconscious during a bout of fever
7. After that he had 4 such attacks in 6 months
8. After the attacks he used to experience severe headache and weakness of limbs for a few hours.
9. During these attacks he used to froth in the mouth, bite his tongue, injuring it twice.
10. Was prescribed medicines which he is still taking, and a symptomatic since 1½ years.
11. Patient and parents want to know if tablets to be continued, and if he can get married.

Questions

Q. 1. The following are the diagnoses from which you can choose your first, and where appropriate a second diagnosis :

a) Depression

b) Hysterical conversion symptoms

c) Schizophrenia

d) Epilepsy

e) Psychogenic somatic condition

Please circle the appropriate answer wherever a choice is given, and write appropriate answers wherever space is given below.

A. Is a diagnosis possible ? YES/NO

B. If a diagnosis is possible, what is the diagnosis ?

.....

C. If you have made a first diagnosis, on what data in the clinical history do you base your diagnosis ? Please mention only the numerical numbers of the respective data in the history.

.....

Q. 2. A. Would you like to seek any further information in this case ? Please circle the appropriate answer. YES/NO

B. If you like to seek further information, what informations would you like to seek ? (Please be brief)

.....

.....

.....

Q. 3. What would you do with this patient ? Please circle the appropriate answer.

a. Refer the patient to a psychiatrist for treatment.

b. Refer the patient to a psychiatrist for opinion and advice only and treat the patient yourself.

c. Treat the patient yourself from your own knowledge and experience.

Q. 4. If you treat the patient yourself, what drug and what daily dosage would you use ?

.....

Q. 5. A. What are the possible side effects of the drug which you prescribe and how would you manage them ?

B. How long should the treatment be continued ?

Q. 6. What explanation and advise would you give the patient and/or his family. Please try to be brief in this answer.

Q. 7. Any comments or remarks about this case you would like to make that is not covered above ? Please be brief.

Appendix–4

Dept. of Psychiatry : Community Mental Health Unit

NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES,
BANGALORE-29

KNOWLEDGE & ATTITUDE QUESTIONNAIRE

PART—I

Read the following statements carefully. If you agree with a statement put a tick mark in bracket. If you don't agree with the statement put an ('X') mark in the bracket. If you can't say anything put a ('—') mark.

1. Anybody under stress can become mentally ill. ( )
2. Black magic or evil spirits are the causes of mental illness. ( )
3. Masturbation, semen loss or excessive sex cause of mental illness. ( )
4. Masturbation, semen loss produce weakness, memory loss or impotence. ( )
5. Mental patients do suffer when they are teased. ( )
6. Mental illness is contagious. ( )
7. Mental patients are always dangerous. ( )
8. Mental illness is generally curable. ( )
9. Marriage can cure mental illness. ( )
10. Mental illness can be treated in your local hospital. ( )
11. A treated mental patient can work with responsibility. ( )
12. In addition to drugs, mental patients need love and encouragement ( )
13. Once drugs are prescribed patients need not consult the doctor again. ( )
14. Some illness in pregnant mother can cause mental retardation in the child. ( )
15. Poor development of the brain is the cause of mental retardation. ( )
16. Mal-nourishment can cause mental retardation. ( )

17. To improve the intelligence of mentally retarded children, good tonic/tablets/injections are to be given. ( )
18. Earlier and proper training help these children to become better. ( )
19. Black magic/evil spirits cause fits. ( )
20. High fever can cause fits in children. ( )
21. Head injuries can cause fits. ( )
22. If mother or father suffers from fits all their children will suffer from fits. ( )
23. Worms in the abdomen are the cause for fits. ( )
24. Some changes in the brain are the cause for fits. ( )
25. Fits are contagious. ( )
26. Fits are generally curable. ( )
27. Placing an iron object in the hands of the patient stops the fit. ( )
28. One should hold the limbs of the patient to minimise the convulsions. ( )
29. When a person gets a fit, he/she should be turned to a side and left to himself. ( )
30. To facilitate early recovery, the unconscious patient should be given a drink (water/coffee/tea). ( )
31. If a patient who is on treatment gets a fit, it means, the drug is useless. ( )
32. If a patient who is on treatment gets a fit, it means either he is irregular in taking medicine or dose is insufficient. ( )
33. If an epileptic patient gets fever, cough etc., he should stop anti-epileptic medicines. ( )

PART—II

Read the following statement carefully. For each statement five probable answers are given. *Select one most appropriate answer* and put a tick mark.

1. Severe mental illness (madness) is

   Totally hereditary. If parents are ill, children do become mad.
   Partially hereditary. Children may get the illness.
   Not hereditary. Children do not get the illness.
   None of the above.
   I don't know.

2. Mentally ill people talk and behave peculiarly because

   They do so deliberately for fun,
   They have unusual experiences

Effect of black magic

Effect of evil spirits.

Excess bile juice.

3. To control an excited unmanageable mental patient.

Tie him with rope/chain and lock him up in a room.

Give him drugs.

Brand him

Scare him by beating

Starve him

4. Mental illness can be cured by

Exercise

Proper medication

Leaving him alone

Starving/branding

Pilgrimage to a temple, holy place and conducting pooja.

5. Mentally ill people on treatment, improve faster by

Complete bed rest

Doing some useful work

Not doing work

Not doing strenous work

I don't know.

6. Mentally ill people can be effectively treated by

Mantravadi/traditional healers only.

Any trained doctor

Specialists only

Special/big hospitals only.

None

7. Mental Retardation is

A physical illness

A mental illness

Both physical and mental illness

A state of sub-normal intelligence

None of the above

8. Fits are cured by

Consulting mantravadi, traditional healer or temple

Branding

Special diet

consulting a modern doctor

Leaving the patient alone.

9. Patients with fits

Do not need drugs

Need drugs only when they get an attack

Need drugs for a few days or months after an attack

Need drugs very regularly for 5 years

Need drugs life long.

10. If an epileptic patient does not take drugs for *one day*

Nothing will happen

He may not get sleep

He may get headache/stomach ache

He may get a fit

I don't know what happens.

11. Epileptie patient who is on treatment, in the beginning

Should not work

Can do any work anywhere.

Should not go to school

Should not work near fire, water, in heights or drive a vehicle. He can do any work observing these precautions.

He should not play or participate in recreation.

Name.....

Age.....Yrs. Education.....

Service.....

Address.....

.....

.....

Date..... Signature

Appendix 5

COMMUNITY PSYCHIATRY UNIT

DEPARTMENT OF PSYCHIATRY : : NIMHANS

Dear Doctor,

Please read the clinical description given below very carefully. Please answer all the six questions.

CLINICAL HISTORY No. A. 1.

1. 17 year old male student, comes with parents.
2. Duration of symptoms—1 year.
3. One year ago, soon after lying down to sleep ; he screamed.
4. He was then found to be unconscious
5. All his four limbs were held straight and jerking in rhythmic fashion.
6. He had passed urine while unconscious
7. He soon became conscious but remained dull for the day
8. Had one more such attack 6 months ago, two more in the last 3 weeks.

CLINICAL HISTORY No. A. 2.

1. 20 years old married housewife.
2. Duration of symptoms—2 years, and more since 6 months.
3. Attacks of bouts of belching varying in periodicity and duration.
4. She got married 2½ years ago.
5. She has a 7 months old baby girl but wanted a male baby.
6. She is free of symptoms for a few months at a time whenever she visits her parents or parents visit her.

CLINICAL HISTORY No. A. 3.

1. 30 years old man, merchant.
2. Since 2 years, he is having pain abdomen which come at any time of the day but never during night.

3. He has consulted many doctors, special X-rays have been taken but no abnormality detected.
4. He has neglected his business and always talks and worries about his illness.
5. His mother died 2 years back due to cancer of the stomach.

CLINICAL HISTORY No. A. 4.

1. 32 years old factory worker was known to be a reliable good worker.
2. From 4 months he does not do his work but goes round the factory advicing others and offering his help to others.
3. He claims that he is the Manager and in a short period would own a factory. He assures that he would give two salaries every worker in his factory.
4. He has become quarrelsome and a week back threatened his supervisor that he would kill him.
5. He is irregular in taking food and keeps the tape recorder playing throughout night.
6. This is the third episode, he recovered within 4-5 months in the earlier episode.

CLINICAL HISTORY No. A. 5.

1. 36 years old married housewife with 3 children.
2. Duration of symptoms—one month.
3. Loss of sleep.
4. Does not get sleep after 2 a.m. whereas previously she used to wake up at 6 a.m.
5. Loss of appetite.
6. Loss of interest to do anything.
7. Has spells of crying for no apparent reasons and she feels helpless and worthless.
8. Has become irritable.

CLINICAL HISTORY No. A. 6.

1. 20 years old male college student.
2. Brought by hostel mates.
3. Duration of symptoms—one month.
4. Unprovoked anger, and at times physically violent.
5. Accuses his room mates of trying to poison him.
6. He complains that his thaughts are automatically being broadcast on radio.

7. His friends have noticed that since about one year he is becoming more and more withdrawn and uncommunicative. No bad habits.

CLINICAL HISTORY No. B. 1.

1. 15 years old girl, comes with mother.
2. Duration of symptoms — 4 months.
3. Since 4 months had 7 attacks of suddenly becoming unconscious for ¼ hour or so.
4. While she was standing, on two such attacks, she had fallen and sustained injuries.
5. After getting up from the attack she complains of headache for a day.
6. During a few attacks, she had bitten her tongue.
7. All the 4 limbs are reported to shake during the attacks.

CLINICAL HISTORY No. B. 2.

1. 20 years old girl.
2. 1 year back, got married to a boy whom she did not like.
3. Since one year, often she is getting headache and always complaints of weakness, lack of appetite.
4. 4 months back, when her husband scolded her she fell unconscious and was said to be possessed by a spirit.
5. Now she is in her parents house and refuses to go to the husband's house. There, she is symptoms free.

CLINICAL HISTORY No. B. 3.

1. 25 years old factory worker.
2. One year back, he got chest pain while working and immediately went to the factory doctor.
3. After examination, doctor said 'nothing wrong' and gave him some tablets.
4. Being not convinced, he consulted heart specialist who also told him that his heart was in good condition.
5. But he continues to have chest pain, increase heart beat, weakness. He thinks that doctors have failed to detect the nature of illness. He always worries about his health. He does not work well.
6. His father had died due to heart attack one year back.

CLINICAL HISTORY No. B. 4.

1. 25 years old lady normally gets good sleep but could not sleep on two previous nights.
2. When asked she does not give any specific complaint except white discharge per vaginum. No associated itching or bad smell reported.
3. She cannot associate any issue or happening with these disturbed nights. But she is anxious about whether they would repeat again.
4. She leads a happy married life and denies any problem and is happy with herself and other family members.

CLINICAL HISTORY No. B. 5.

1. 45 years old lady.
2. She attained menopause 2 years ago before which she had irregular menstruation for one year.
3. Since 2½ years she is dull, showing less and less interest in daily activities.
4. Often she weeps and says that it is better to die.
5. At times she loses temper and accuses her sons that they are neglecting her. But others know that her children like her very much.

CLINICAL HISTORY No. B. 6.

1. 17 years old girl, S.S.L.C. student.
2. She got first class in 8th standard but later she is getting lower marks in the examinations.
3. Now-a-days she does not mix with others and prefers to be alone.
4. She believes that others talk ill of her, but everybody knows that it is not so.
5. At times, she talks and laughs to self for no known reasons.
6. At times, she behaves in such a way that others cannot understand her.

The person is suffering from physical illness/mental illness/both/no illness.

Please answer the following questions :

This person is suffering from physical illness/mental illness/both/no illness.

1. What is the diagnosis ?
2. What drugs in what daily dosage would you prescribe this patient ?
   (If you think that this patient does not require any drugs, please write 'Not required')

Drugs Daily dose

3. What are the side effects of the above drugs ?
4. How would you manage these side effects ?
5. What advice you would give the patient/family ?
   regarding
   a) Illness
   b) Drugs
   c) Work
   d) Any psychosocial issues which need intervention ?
      Mention them.

6. When would you refer this patient to a psychiatrist or specialist ?
   a) After trying the maximum dose of.....
      for ..... (time) and no improvement.

   Or

   b) Pathology is severe enough to need specialist's help.

   Or

   c) If the following symptoms appear.

Appendix 6 (a)

Confidential

DEPARTMENT OF PSYCHIATRY

COMMUNITY MENTAL HEALTH UNIT : NIMHANS : BANGALORE – 560029

CASE RECORD

No. ..... Date.....

Name..... Age..... Sex M/F

Husband/Father's name .....

Place ..... Education..... Occupation .....

Marital status : S/M/W/Separated Family : N/Ext./Joint. Religion : H/MC/O.

Has come alone/with .....

Referred by : Self/Other pt./G. P./Hosp. Dr.

Previous consultation _____

_____

I. (a) Complaints and duration :

(b) When was the patient totally alright ? _____

(c) How the illness started ? Sudden/Gradual

(d) Any precipitating factor ? Give details.

(e) Illness : Continuous/Episodic ? If episodic how many ?

(f) Description :

II. Biological functioning :

Apetite	Sleep	Bowel and Bladder	Sexual

III. Social functioning :

Personal hygiene	Work	Social activities

IV. Past History of mental illness : When and details.

V. Personal History :

(a) Childhood and schooling :

(b) Sexual and marital :

(c) Occupational :

(d) Habits :

VI. Details of the family including history of mental illness in the family :

VII. Mental State Examination :

(a) Appearance and behaviour including level of consciousness.

(b) Thinking and speech (include content with examples)

(c) Emotions (both subjective and objective)

(d) Perception :

(e) Attention, concentration, and memory :

(f) Intelligence and judgement :

(g) Insight : Absent/Partially presenet/Present.

VIII. Physical examination :

IX. Diagnostic formulation and diagnosis :

X. Treatment :

(a) Drugs

(b) Psychological

(c) Social

Mode of disposal : Refered to _____

or adviced to come on _____

(Name and Signature)

Discussed with _____ (Consultant)

Consultant's diagnosis _____

His remarks :

Signature.

COMMUNITY MENTAL HEALTH UNIT
NIMHANS–BANGALORE

HISTORY TAKING PROFORMA REGARDING EPILEPSY

Patients Name ..... Place .....

Age ..... yrs Sex : Male/Female

Education .....

Occupation .....Father/Husband's Name .....

Informants Name .....

---

1. What is the patient's problem ?
2. Duration
3. Frequency of fits
4. Duration of fits
5. Loss of consciousness Yes/No
6. Sudden fall Yes/No
7. Tonic/Clonic movements Yes/No
8. Tongue Bite/Bleeding from mouth. Yes/No
9. Incontinence urine/faces. Yes/No
10. Evidence of Injury following a fall. Yes/No
11. Fits during sleep/when alone Yes/No
12. Do attacks of fits resemble each other or different ?

Your opinion : Epilepsy/Hysteria/Difficulty to say.

II. To enquire with the family members :

1. What do you do when he has fits ?
2. Any treatment initiated ? By whom ? What is the change ?
3. Since when he is taking tabs ? How ?
4. Regularity in medication ..... Yes/No

If no–reasons _____

---

5. What problems he has developed following fits ?
6. Effect of patients illness on the family ?
7. How long has the doctor adviced to take tabs ?
8. How the tabs helped you ? Any problems ?
9. What precaution's patient should observe ?

III. What is your opinion about the patient ?
   a) Normal
   b) MR : mild/mod/severe
   c) Handicap (specify)

IV. 1. Does any one else suffer from fits in the surroundings ?
   who ? details
   2. Are they taking tabs ? If no, why ?
   Have you tried to talk to them ? effects ?

V. Illness and effect on the family
   Your opinion.

Date : Name of the Health Worker

COMMUNITY MENTAL HEALTH UNIT
SAKALAWARA, NIMHANS, BANGALORE-29

PSYCHOSIS PROFORMA

Patient's Name ..... Age .....

Sex : Male/Female Father/Husband's name .....

Educational status .... Place .....

Marital status ..... Occupation .....

Informant's name and relationship to the patient

Number of family members ..... Home atmosphere ? .....

1. Chief complaints and duration.

   1.

   2.

3.

4.

5.

2. When was the patient perfectly alright ?
3. Onset of illness ? sudden/gradual
4. Stress factors preceeding the outset of illness ? Present/Absent
   If present details ?
5. Continuous illness/episodic illness
6. Illness : Deterioating/improving/Status Quo ?
7. What did the family do following the on set of illness ?
   Any treatment given ? What is the effect ?
8. Amount of money spent for such treatment ?
9. What was their belief about the cause of the illness before contacting Sakalawara Hospital ?
10. Problems faced by the family members due to patient's illness ?
11. Family H/O mental illness ? present/absent. If present, details.
12. Does the patient have physical illness apart from mental illness ?
    Diabetes/Hypertension/Tuberculosis ?
13. What is the change in the patient following the treatment ?
    Improvement (in percentage)
14. Does the patient take medication regularly ? Yes/No
    Any side effects ?
15. Do you take the patient to the hospital every month ?
    Yes/No/any problems ?
16. Describe the day-today activities of the patient.

Appetite	Sleep	Social behaviour	work and personal hygiene

17. Current clinical status

Personal hygiene—Poor/Normal

Talk — Excess/Normal/Decrease
Irrelevent/Incoherent
cannot understand

Behaviour — Normal/Dull/excess
understandable/peculiar

Level of consciousness — normal/altered-cannot identify the family people.

Work :

Side effects of the drugs.

a) Drowsiness b) Rigidity c) Tremors of hands
d) Dryness of mouth e) Drooling of Saliva f) Others

18. What is your global assessment of the patient's problems ?

19. Your comments about the patient/family ?

20. Are there any doubts ?

Date .....

Signature of the health worker

Appendix 7

COMMUNITY MENTAL HEALTH UNIT
NIMHANS : BANGALORE-560029

Dear Doctor,

It has been a pleasure to have you with us for the training course. We would like to know your opinion, comments and suggestions so that we can further improve the training programme. Please feel free to express your experiences and comments. Under each heading, mention whether it was useful to you or not, whether it was sufficient and your suggestions for improvement.

1. Formal lecture sessions.

2. Clinical demonstration of cases in Sakalawara/NIMHANS.

3. Video-demonstration of cases.

4. Village visits.

5. Anekal and other PHC/PHU visits.

6. Slide and educative materials (Books and charts).

7. NIMHANS Movies.

8. Manual :

9. The timings and duration of lectures and other activities.

10. What is your opinion regarding conducting the programme in Sakalawara campus ?

11. Food, accommodation and other facilities in the campus.

12. Any other comment/suggestion.

Date .....

Name and Signature

Appendix 8

ಸಮುದಾಯ ಮನೋವೈದ್ಯವಿಭಾಗ, ರಾಷ್ಟ್ರೀಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಮತ್ತು ನರವಿಜ್ಞಾನ ಸಂಸ್ಥೆ, ಬೆಂಗಳೂರು–560 029, ಕರ್ನಾಟಕ ರಾಜ್ಯ

NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES, BANGALORE–29
COMMUNITY PSYCHIATRY UNIT

INFORMATION ABOUT CASES

ರೋಗಿಯ ಬಗ್ಗೆ ಮಾಹಿತಿ

Name of the doctor/M.P.H.W. ..... Center/Subcenter .....

ವೈದ್ಯರ/ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರ ಹೆಸರು ಕೇಂದ್ರ/ಉಪಕೇಂದ್ರ

Date ತಾರೀಖು	Name of the Patients ರೋಗಿಯ ಹೆಸರು	Age ವಯಸ್ಸು	Sex ಲಿಂಗ	Address ವಿಳಾಸ	Symptoms			Duration ಎಷ್ಟು ಸಮಯದಿಂದ	What are the complaints ತೊಂದರೆಗಳು ಯಾವುವು
					Mental illness ಮಾನಸಿಕ ಖಾಯಿಲೆ	Fits ಮೂರ್ಛೆ ರೋಗ	Mental retar-dation ಬುದ್ಧಿ ಮಂದತ್ವ		
(1)									
(2)									
(3)									

Appendix 9 (a)

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
BANGALORE

HEALTH WORKER'S REPORT

Duration ..... months.

Name ..... Date .....

P.H.U. ..... P.H.C. .....

Tq. ..... Dist. .....

		Mental	M.R.	Epilepsy
1. No. of cases identified in the area.	....			
2. Brought to the PHC.	....			
3. Diagnosed, advised and followed.	....			

FOLLOW-UP CASES

Name	Diagnosis	Drugs	Present state

DROP-OUT/NO FOLLOW-UP

Name	Diagnosis	Why drop out	What you have done

Signature

Appendix 9 (b)

NATIONAL INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES, BANGALORE

DOCTOR'S REPORT

Duration ..... months.

Name ..... Date .....

P.H.C. ..... Tq. .....

Dist. .....

	Mental illness		M. R.	Epilepsy
	Psychosis	Neurosis		
1. No. of cases came directly to you.				
2. No. of cases referred by Health worker.				
Total				
3. No. of cases on follow-up				
4. No. of cases — drop out				

REPORT ABOUT HEALTH WORKERS

Name			Name		
P.H.U.			P.H.U.		
	Identified	Follow-up		Identified	Follow-up
Mental illness			Mental illness		
M. R.			M. R.		
Epilepsy			Epilepsy		

Any specific difficulties : Brief descriptions.

Signature & Seal.

Appendix 10

RECORD & FOLLOW UP BOOK FOR MENTAL PATIENTS

Patient's Name ..... Age.....

Place ..... Occupation .....

Husband/Father's Name ..... Date .....

How you came to know about the patient ? .....

Loss of consciousness and shaking of limbs	Abnormal talk behavior, Disturbed sleep, appetite No cleanliness disturbing to others	Dull, sad Talks about dying sleep/appetite disturbance	From the beginning low intelligence learning difficulties dependant on others
How long.....	How long	How long	Since birth ?
Frequency	How it started suddenly/slowly	How it started suddenly/slowly	Since what age .....
			Body defects .....
Sudden fall ?	Any precipitating event	Reasons	Fits
Injuries ?	.....	.....	very mischievious
Shaking of limbs ?	.....	.....	
Regular shaking ?	Physical illness	Sits idle	What the child can do now
Frothing ?		Suicidal thought	.....
In-continence of Urine/faeces	Fever	Suicidal attempt	.....
	Head injury	Physical illness	.....
Problems after shaking of the limbs	Intake of Alcohol/drugs	.....	.....
Attack during sleep/ when alone	Patient is excited		
Last fit on	Unconscious Not so excited		
Epilepsy	Psychosis	Depression	Mental Retardation

Emergency : to be referred immediately to the hospital.

Not an emergency.

FOLLOW-UP

When the patient consulted the doctor in PHC .....

Disease .....

Drug and dosage .....

Signature of the Supervisory staff.

Signature of the Doctor.

Date	Regularly takes medicines	Side effects	How is the patient	Has he seen the doctor	Your advise & Signature

Appendix 11 (a)

MEDICAL OFFICERS PRE - POST-TRAINING ORIENTATION

(Using Video-Case-Interviews)

Patient's Name :

1. What do you feel about this person ? Normal/Ill/cannot say
2. If Ill, is it a physical illness/mental illness/both
3. What is your diagnosis ?
4. What are the points in favour of this diagnosis ?

   i) ii)
   iii) iv)
   v) vi)
5. Would you be able to look after this case in your centre ? Yes/No
6. If yes, what would be your approach to management :

   1. Drugs 2. Drugs & counselling 3. Counselling.
7. If yes, what drugs you will prescribe and in what doses ?

   i) dose
   ii) dose
   iii) dose
8. What side effects would you expect from the use of above drugs and how would you manage them ?

   i)
   ii)
   iii)
9. What will be the duration of treatment ?
10. What specific advices would you give to the patient or to the family members ?

    i)
    ii)
    iii)
11. What is the prognosis of this case at the end of 6 months of treatment ?

    a) Totally symptom free b) A few residual symptoms present
    c) Moderate improvement d) Status-quo
    e) Condition become worse f) Cannot say.

Name of the Doctor : ..... Signature .....

Appendix 11 (b)

DEPT. OF PSYCHIATRY : COMMUNITY MENTAL HEALTH UNIT
NIMHANS, BANGALORE

KNOWLEDGE AND ATTITUDE QUESTIONNAIRE

Read the following statements carefully. If you agree with a statement put a tick mark in bracket. If you don't agree with the statement put an ('×') mark in the bracket.

( ) 1. Mental illness is hereditary. Children of the mentally ill also suffer from mental illness.

( ) 2. Any body under severe stress can become mentally ill.

( ) 3. Black magic or evil spirits are the causes of mental illness.

( ) 4. Masturbation, semen loss or excessive sex cause mental illness.

( ) 5. Masturbation. semen loss produce weakness, memory loss or impotence.

( ) 6. By coming in contact with or living with mentally ill, one becomes mentally ill.

( ) 7. Mentally ill persons deliberately talk and behave abnormally.

( ) 8. Mental patients are always dangerous. We should keep ourselves away from them.

( ) 9. Mental patients do suffer when they are teased.

( ) 10. Marriage can cure mental illness.

( ) 11. Mental illness can be cured in temples and pilgrimage centres.

( ) 12. It is safe to keep mentally ill persons inside the mental hospital.

( ) 13. Mental illness can be cured.

( ) 14. Mentally ill persons can be managed in PHC and other local hospitals.

( ) 15. A treated mental patient can work with responsibility. He is reliable.

( ) 16. Mental retardation in which there is delay in growth and subnormal intelligence is a type of physical or mental illness.

( ) 17. If a woman becomes pregnant after the age of 35, there is an increased risk of she giving birth to a mentally retarded child.

( ) 18. Illnesses like viral fever, syphils, diabetes in the pregnant mother can cause mental retardation in the child.

( ) 19. Difficult labour can lead to mental retardation in the child.

( ) 20. Lack of proper nourishment to the child can cause mental retardation.

( ) 21. Poor development of the brain results in mental retardation.

( ) 22. Mentally retarded child, as it becomes older becomes alright on its own.

( ) 23. Whatever you do, mentally retarded child will not improve.

( ) 24. It is better to admit the mentally retarded child into a hospital or an institution.

( ) 25. Fits are contageous. By touching the saliva of the patient, one can contact the illness.

( ) 26. Fits are hereditary.

( ) 27. High fever can cause fits.

( ) 28. Brain damage as a result of head injury and other factors can cause fits.

( ) 29. Fits (Epilepsy) are not generally curable.

( ) 30. Epileptic patient should observe strict diet restrictions.

( ) 31. Branding (burning the skin with hot iron/bangle piece) helps in the control of fits.

( ) 32. If a patient who is on treatment gets a fit, it means, the drug is useless.

( ) 33. If a patient who is on treatment gets a fit, it means either he is irregular in taking medicine or dose is insufficient.

( ) 34. If an epileptic patient gets fever, cough etc. he should stop taking anti-epileptic medicines during that period.

( ) 35. Epileptic patient on treatment should not work and take rest. The epileptic child should not go to school and should not play.

Appendix 11 (c)

DEPARTMENT OF PSYCHIATRY : COMMUNITY MENTAL HEALTH UNIT
NIMHANS : BANGALORE-29

HEALTH WORKERS' TRAINING PROGRAMME IN MENTAL HEALTH

1. Name of the Health Worker :
2. Primary Health Centre :
3. Age :
4. Total No. of years of service :
5. Educational qualification :
6. Total number of population allotted to you :
7. Total No. of mentally ill patients you know in your area :
   a) Mentally ill
   b) Epileptics
   c) Mentally retarded.
8. Total number of people taking treatment :

Read carefully ; Select and tick the best answer from the three answers given to each statement :

1. Expected number of severely mentally ill persons in every 1000 population.
   a) 0–2 b) 3–6 c) 12-15
2. Causes of severe mental illnesses.
   a) Some changes in the brain b) Bad deeds of past life
   c) Excess heat or bile juice.
3. Who suffer from severe mental illness ?
   a) Poor people only b) Old persons only
   c) Anybody
4. How long drugs have to be given to a mental ill person ?
   a) a few days b) life long c) a few months or years

5. Name of the drug used to treat severe mental illness.

   a) Phenobarbitone b) Chlorpromazine c) Calmpose

6. By taking chlorpromazine tablets, patients develop

   a) Severe side effects b) A few side effects
   c) No side effects.

7. If a patient who is taking chlorpromazine tablets has developed rigidity and tremors of legs and hands, excess salivation, it is due to

   a) side effects of the drugs b) not due to drug
   c) a new illness has developed.

8. A patient who is taking treatment for mental illness has to

   a) take complete rest b) do some work c) observe food restrictions

9. When a patient who is on treatment has to see the Doctor ?

   a) regularly once in 2 or 4 weeks
   b) only when there is a problem
   c) Whenever he likes

10. Reasons for a patient to behave violently

   a) People irritate and tease him
   b) Effect of full moon and new moon
   c) Anemia

11. To calm the patient who is excited and violent.

   a) Tie his hands and legs and threaten him
   b) Enquire his difficulties. Who is troubling him, and
   c) Pour a bucket of water on him

12. A patient who is having sadness and crying spells, the important question we should ask to decide whether he needs emergency treatment.

   a) How is your appetite and sleep
   b) How your family members look after you
   c) Do you feel that it is better to die instead of living.

13. When you see a patient with ideas of suicide or suicidal attempt :

   a) Refer the patient immediataly to the doctor
   b) Advice him that it is a sin to think of commit suicide
   c) Lock the patient inside the room.

14. To identify severely mentally ill the best way to enquire is

   a) Are there mad people in your village ?
   b) Do you know anybody who talks to himself, laugh and cry to himself behaves in a strange way
   c) Do you know anybody with disturbed mind in your village ?

15. Where do you refer the mentally ill patient that you have identified.

a) Bangalore or Dharwad mental hospital
b) Temple or any popular traditional healing centre
c) PHC or PHU

16. If family members report that the patient is unwilling to come to the hospital, what do you do ?

a) I will tell them to bring the patient by force or any other measures.
b) I will tell the patient that he need not be afraid of the hospital and he can come along with me to the hospital.
c) No problem, let him come when he likes.

17. When you give suggestion, if the family members do not follow it, I will

a) Ask why have they not followed my instructions. What is the problem ?
b) Warm them that if they do not listen to me, they have to face consequences
c) I get frustrated and think that it is useless to work for them

18. If a psychiatric patient does not take medication regularly you have to tell to them that

a) The patient may not sleep properly
b) Improvement may be delayed or illness may relapse
c) Doctor gets angry on you

19. If patient and family members insist to go to temples or to magic healers for treatment

a) I will tell them 'you are stupid and are not willing to give up your blind beliefs'.
b) If you believe in this you can do it, but please come and take medicines in the hospital.
c) If you go to places, other than the hospital, you are going to waste lot of money.

20. When you tell people to bring mentally ill persons for treatment and if they do not believe it. What measure will be more useful to make them to come to the hospital.

a) Tell them again and again and persue them.
b) Organise talks from doctors and show films on mental health
c) Show them the improved patients who got benefitted through the hospital care.

21. Causes of epilepsy

a) Abnormal electrical changes in the brain

b) Effects of full moon and new moon
c) Nervous weakness.

22. No. of epileptic patients expected in a given 1000 population
a) 15 to 20 b) 8 to 10 c) 2 to 4

23. When a person gets an epileptic attack
a) One should hold his hands and legs
b) Allow more air to come and fan him.
c) Turn him to a side and look after him till he recovers

24. Name of the drug used to treat epilepsy :
a) Tablet chlorpromazine
b) Tablet imipramine
c) Tablet phenobarbitone

25. If a patient misses one dose of antiepileptic drug :
a) He may not sleep properly
b) He may get an epileptic fit
c) Nothing will happen to the patient

26. Side effects of Phenobarbitone
a) Excessive sleep
b) Intelligence may decrease
c) Nausea and vomiting.

27. When a child suffering from Fever fits, gets fever again.
a) Immediately antiepileptic injection has to be given
b) Bring down the fever by cold water pack or tepid sponging of the body.
c) Give phenobarbitone tab.

28. How long medication has to be given for an epileptic patient.
a) 5 years from the day of starting medication
b) 3 years from the day of last attack of fit,
c) 5 years from the day of last attack of fit

29. In order to improve a mentally retarded child one has to give the child :
a) Good tonic, brain stimulating medicine
b) Training to make the child learn self help skills
c) Specialist's help in a big institution.

30. To get the financial help from the Government, M.R. child should have
a) Intelligence of less than 35% and the parents' income less than Rs. 3600/ year.
b) On applying all the M.R. Chidlren will get it.
c) The child's age should be minimum 5 years.

Appendix 12

COMMUNITY MENTAL HEALTH UNIT, DEPARTMENT OF PSYCHIATRY, NIMHANS, BANGALORE

TRAINING IN MENTAL HEALTH FOR HEALTH WORKERS : 6 DAYS

	9.00-11.00 A.M.	11.15-1.00 P.M.	2.00-3.15	3.15.-5.00 P.M.
Monday	Reporting and knowing each other. Pre-training assessment.	Introduction to Tr. Programme. Mental health needs of the community.	Brain and Behavior.	What is mental illness Types, Causes and Treatment.
Tuesday	Causes and symptoms of psychosis. Approach to psychiatric patients.	Village visit : Interviewing psychotic patients & their family members.	Depression. Treatment of psychosis	Health education regarding psychosis.
Wednesday	Epilepsy : Causes & Symptoms.	Village visit : Interviewing epileptic patients.	Treatment of Epilepsy. Health education	Minor mental disorders.
Thursday	Mental retardation and its management.	Childhood mental disorders.	Visit to Anekal and Marsur PHC and Interviewing psychiatric patients.	
Friday	People's doubts regarding mental illness and how to educate them.	Discussion on mental health education & Role Play.	Visit to wards at NIMHANS.	
Saturday	Responsibilities of health workers.	Post training assessment and discussion.	Distribution of certificates. Feedback on the course.	

Appendix 13

NATIONAL MENTAL HEALTH PROGRAMME

MENTAL HEALTH CARE RECORDS

Centre : .....Doctor's Name .....

Name : ..... Clinic No. .....

Age : .....Yrs. Sex : ..... Date : .....

Father's/Husband's name : .....

Village/Address : .....

.....

Mode of contact : Health worker/Other patient/Self/Other agency

Duration of complaints : .....

Main complaints :

SYMPTOMS AND SIGNS

* Unconsciousness
* Clouded consciousness
* Injury/tongue bite
* Tonic/Clonic movement
* Incontinence
* Attack in sleep/when alone
* Delayed milestones
* Speech difficulty
* Physical handicaps
* Scholastic backwardness
* Limited social skills
* Fear/Anxiety
* Palpitation
* Giddiness
* Headache
* Tremors
* Excess activity
* Dull/Withdrawn
* Excess/Understandable speech
* Hallucination
* Delusions (False beliefs)
* Elation/excess happiness
* Violence and aggression
* Anger, irritability
* Sadness
* Suicidal ideation/attempt
* Disorientation
* Loss of memory
* Sleep and appetite disturbance
* Self neglect
* Sadness
* Brief episodic abnormal behaviour

* Difficulty to concentrate
* Body aches/pains
* Weakness
* Sexual problems
* Frequency of symptoms

Family history : Mental illness/M.R./Epilepsy

Past History : Mental illness/epilepsy

Associated events : Fever/Head injury/Alcohol use/Psychosocial/stress/ Significant physical illness

---

Physical examination : Normal/Abnormal (Specify)

Investigation :

Diagnoses : Schizophrenia/Mania/Depression/Organic psychosis/Mental retardation/Drug dependence/Anxiety neurosis/Depressive neurosis/Hysteria/Major epilepsy/ Focal epilepsy/Febrile fits. (Specify)_____
No Diagnosis :

Treatment :

Follow-up on _____ Signature of M.O.H.

FOLLOW-UP RECORDS

Date	Clinical condition including side effects	Treatment	Follow-up date

Appendix 14

MENTAL HEALTH PROGRAMME

CASE RECORD FOR MENTAL PATIENTS

Name of the Health worker ..... Centre .....

Patient's Name ..... Age .....

Father/Husband's Name ..... Caste .....

Place & Address .....

.....

Identified on .....

Duration of Illness ..... How frequent .....

Epilepsy	Mental Illness	Mental Retardation
Sudden fall	Abnormal behavior	Age inappropriate intelligence
Injuries	Too much/too less emotions	No proper growth
Shaking of limbs	More/less/abnormal talk	Learning difficulties
Froth in the mouth	Firm, false beliefs	No head control
Passes urine/stool in cloths	Seing/hearing things which are not seen or heard by others	Does not sit
Attack during sleep/when alone	Severe sadness/disinterested	Does not stand
Attack during fever only	Suicidal ideas	Does not talk
Dullness/disturbance after the attack	Altered level of consciousness	Cannot help himself in eating
	Sleep disturbance	Cannot dress himself
	Appetite disturbance	No control over passing urine/stool
	No cleanliness of body	Very mischivous
	Taking alcohol/drugs	Body defects

Emergency :

Not an emergency :

Signature of the Health Worker

FOLLOW-UP NOTES

Drug ..... Dosage .....

Date	Regular intake of medicines	How much improvement ? Any problem ?	Works

Appendix 15

SHORT TERM TRAINING IN MENTAL HEALTH CARE FOR PHC MEDICAL OFFICERS

MULTIPLE CHOICE QUESTIONNAIRE

Name of the doctor : .....

Name of the PHC/PHU/HOSPITAL :.....

Age :..... Qualification : .....

Duration of Service : ..... Date : .....

Dear Doctor,

Read the following questions carefully. Each question of statement is followed by five answers. Put a tick mark against each correct answer. Put '×' mark against each wrong answer. *Note* : There may be more than one correct or wrong answers for each question. Your responses help us to evaluate the training course and improvise, enable you to manage mentally ill with confidence. Feel free to answer, it does not matter if you make mistakes. Do not leave any question unanswered. Thank you.

1. False perception without external stimuli is called as

( ) a) Introjection
( ) b) Projection
( ) c) Hallucination
( ) d) Illusions
( ) e) Delusion

2. A delusion is

( ) a) a disorder of perception
( ) b) not amenable to reason
( ) c) a false belief
( ) d) recognised as silly by the patient
( ) e) a belief of the patient which is not shared by others.

3. Number of psychotic cases expected in 1000 population is

( ) a) 0 to 1
( ) b) 2 to 3
( ) c) 5 to 10
( ) d) 11 to 15
( ) e) 15 to 20.

4. In most of the psychoses changes observed in the brain are related to

( ) a) C.S,F.
( ) b) Hormones
( ) c) Enzymes
( ) d) Neurotransmitters
( ) e) Electrolytes

5. Characteristic features of psychosis are :

( ) a) Delusion
( ) b) Hallucination
( ) c) An idea repeatedly coming to one's mind
( ) d) Lack of touch with reality
( ) e) Disorganised behaviour.

6. Following suggest the possibility of rrganic psychosis.

( ) a) History of fever
( ) b) History of head injury
( ) c) History of Diabetes Mellitus/hypertension
( ) d) History of drug dependence.
( ) e) History of psychosis in the family

7. Characteristic features of organic psychosis include

( ) a) Disorientation
( ) b) Memory disturbances
( ) c) Confusion
( ) d) Excessive talking and screaming
( ) e) Soiling the clothes

8. Functional psychoses are :

( ) a) Hysteria
( ) b) Depression
( ) c) Mania
( ) d) Schizophrenia
( ) e) Reactive psychosis

9. Generally Schizophrenia is :

( ) a) An acute illness

( ) b) An acute illness
( ) c) A recurrent illness
( ) d) A reactive illness
( ) e) A life long illness

10. The following mental functions are disturbed in schizophrenia

( ) a) Thinking
( ) b) Emotions
( ) c) Perceptions
( ) d) Memory
( ) e) Intelligence

11. Maximum dose of chlorpromazine per day which is safe at PHC level.

( ) a) 1200 mg/day
( ) b) 900 mg/day
( ) c) 600 mg/day
( ) d) 300 mg/day
( ) e) 150 mg/day

12. A schizophrenic patient behaves in a bizarre way because

( ) a) He is mad
( ) b) He wants to irritate/punish family members
( ) c) He wants to enjoy himself
( ) d) He responds to hallucinations
( ) e) He responds to delusions

13. Average dose of chlorpromazine (Largactil) to treat schizophrenia

( ) a) 25–50 mg/day
( ) b) 50–100 mg/day
( ) c) 100–300 mg/day
( ) d) 400–600 mg/day
( ) e) 500–800 mg/day

14. Antipsychotic drugs are :

( ) a) Diazepam (Calmpose)
( ) b) Trifluoperazine (Eskazine)
( ) c) Imipramine (Depsonil)
( ) d) Haloperidol (Serenace)
( ) e) Thioradazine (Melleril)

15. Side effects of chlorpromazine include

( ) a) Drowsiness
( ) b) Dryness of mouth

( ) c) Blurring vision
( ) d) Orthostatic Hypoter ion
( ) e) Tremor of limbs

16. Orthostatic hypotension induced by chlorpromazine (largactil) is treated by

( ) a) Antihistamin — Inj-Phenergan
( ) b) Anticholernergic — Pacitane tab.
( ) c) Lithium (Lithium carb)
( ) d) Stoppage of C.P.Z. (Largactil)
( ) e) Gradual getting up from bed — dangling of legs and walk.

17. Duration of treatment in schizophrenia.

( ) a) Same in all cases.
( ) b) Life long
( ) c) Varies from individual to individual i.e. several months to several years.
( ) d) 6 months to 1 year
( ) e) Varies according to the sex of the patient.

18. Schizophrenic patient on drugs

( ) a) Should take complete rest
( ) b) Can take part in recreational activities
( ) c) Should not do hard work
( ) d) Should start working as early as possible
( ) e) Should be left to himself.

19. The common causes of relapse in schizophrenia are

( ) a) Irregular medication
( ) b) Early discharge from the hospital
( ) c) Overprotection by family members
( ) d) Rejection by friends and family members
( ) e) Taking up responsibilities in the family.

20. Characteristic symptoms of mania include

( ) a) Over activity
( ) b) Excessive happiness
( ) c) Grandiose ideas
( ) d) Excessive talk
( ) e) Not spending money

21. Usually an episode of mania and depression lasts for

( ) a) 1—2 months
( ) b) 3 – 6 months

( ) c) 8—10 months
( ) d) 1—2 years
( ) e) 3 years

22. Mania is treated by

( ) a) Lithium carbonate
( ) b) Tab. haloperidol (Serenace)
( ) c) Chlorpromazine (Largactil)
( ) d) E.C.T.
( ) e) Imipramine (Depsonil)

23. Treatment duration for mania/depression is

( ) a) 6 months
( ) b) 9 months
( ) c) 12 months
( ) d) 5 years
( ) e) 5 years.

24. The following are the specific features of depression :

( ) a) Sadness
( ) b) Insomnia or hypersomnia
( ) c) Loss of self esteem or self depreciation
( ) d) Recurrent suicidal ideation
( ) e) Laughing to self

25. Indication for E.C.T in depression

( ) a) High suicidal risk
( ) b) Depression in middle or old age
( ) c) All cases of depression
( ) d) No response to antidepressant drugs
( ) e) Refusing to take drugs.

26. The following are antidepressants

( ) a) Trifluoperazine (Eskazine)
( ) b) Imipramine (Depsonil)
( ) c) Carbamazepine (Mazetol)
( ) d) Amitriptyline(Tryptonol)
( ) e) Doxepin Hcl. (Spectra/Doxetar)

27. Initial dose of antidepressant drug is :

( ) a) 25 mg.
( ) b) 50 mg. to 75 mg.
( ) c) 100 mg.

( ) d) 150 mg.
( ) e) Depends on age and sex of the patient.

28. Which of the following would be a contraindication for the administration of antidepressant drugs :

( ) a) Enlarged prostrate
( ) b) Recent attack of myocardial infarction
( ) c) Glaucoma of the eye
( ) d) Diabetes
( ) e) Hypertension

29. Depression is a recognised complication of treatment with the following drugs :

( ) a) Oral contraceptives (Oestrogen and Progesteron)
( ) b) Reserpine group of antihypertensive drugs.
( ) c) Phenobarbitone
( ) d) Antibiotics
( ) e) Isoniazoid (I.N.H)

30. Characteristic features of reactive psychosis are :

( ) a) Strong emotional event precedes the onset of psychosis
( ) b) Only depressive symptoms are present
( ) c) Symptoms are related to the precipitating factor
( ) d) Lasts for 4 to 6 weeks
( ) e) Seen only in women

31. Neuroses is

( ) a) A type of neurological disorder
( ) b) An increased or prolonged emotional reaction to a stress
( ) c) A result of brain damage
( ) d) A result of very unhappy childhood
( ) e) Seen only in young and women

32. In patients with neurosis, it is explained that

( ) a) Their limbic system is not effectively functioning
( ) b) They are unresolved conflicts in their unconscious mind
( ) c) There are hormonal deficiencies
( ) d) They deliberately exhibit the symptoms to draw the attention of others and to escape from the responsibilities
( ) e) Their ability to cope with stress is less.

33. Expected number of patients with neurosis in a community is :

( ) a) $<1\%$
( ) b) $1-2\%$
( ) c) 5%

( ) d) 10%
( ) e) 25 %

34. The following are the common features of neurosis :

( ) a) Multiple and vague somatic symptoms
( ) b) Many consultations with different doctors and all routine investigation reports being normal.
( ) c) Feelings of insecurity and inferiority
( ) d) Presence of neurological deficits.
( ) e) only females are affected.

35. The following are the types of neuroses.

( ) a) Anxiety
( ) b) Hysteria
( ) c) Obsessions and compulsions
( ) d) Hypochondriasis
( ) e) Depression

36. The following are the common areas of stress in neurotic patients :

( ) a) Family
( ) b) Financial
( ) c) Occupational
( ) d) Sexual
( ) e) Religion and caste

37. The following methods of treatment help the patients to recover from neurosis.

( ) a) Drugs only (anxiolytics, antidepressants)
( ) b) E.C.T.
( ) c) Counselling and drugs
( ) d) Emotional support from the doctor and family members.
( ) e) Tonics and vitamins (specially B_1, B_6, B_{12})

38. To develop a good doctor patient relationship

( ) a) The doctor should be a good listener
( ) b) The doctor should tell the patient that he would make an honest and appropriate effort to treat the patient
( ) c) The doctor should carry out all the investigations as desired by the patient
( ) d) The doctor should give costly medicines, if possible free of cost
( ) e) Doctor should give a lot of advice

39. The following factors are associated with anxiety

( ) a) Palpitation
( ) b) Dizziness

( ) c) Warm hands
( ) d) Dry mouth
( ) e) Increased frequency of micturition

40. The following are useful in the treatment of anxiety :

( ) a) Chlorodiazepoxide (Librium) or Diazepam (Calmpose)
( ) b) Propanolol (Inderal)
( ) c) Chlorpromazine(Largactil) or trifluoperazine (Eskazine)
( ) d) E.C.T.
( ) e) Relaxation

41. Hysteria is

( ) a) Equivalent to malingering.
( ) b) A condition wherein the individual tries to communicate his distress through some symptoms.
( ) c) A conditition where the person exhibits symptoms deliberately to draw the attention of others and get sympathy
( ) d) A mental illness which appears during puerperium (after delivering a child) in women.
( ) e) Seen only in women.

42. The following are true in a hysterical attack :

( ) a) No self injury
( ) b) No double incontinence
( ) c) Irregular, asynchronous, bizarre movements of the body
( ) d) Induced by suggestion
( ) e) Pupils dilated and the plantar reflex is extensor

43. Treatment for hysteria is :

( ) a) E.C.T.
( ) b) Gardenal sodium (phenobarbitone)
( ) c) Counselling
( ) d) Chlorpromazine (Largactil)
( ) e) Scare the patient by inducing physical pain

44. Number of mentally retarded children expected in 1000 population is

( ) a) Less than 10
( ) b) 10 to 20
( ) c) 21 to 30
( ) d) 40 and above
( ) e) Not known

45. Preventable causes of mental retardation are :

( ) a) Birth trauma

( ) b) Protein deficiency in pregnant mother's or in children
( ) c) untreated diabetes or syphillis in pregnant mother's
( ) d) Untreated epilepsy in children
( ) e) Brain infection in child

46. The characteristic features of M.R. in the child

( ) a) Delayed mile stones
( ) b) Dwarfism
( ) c) Slow in learning
( ) d) Always crying and throwing temper tantrums
( ) e) Age inappropriate behaviour and ability

47. The following help the M.R. child

( ) a) Medicines like Encephabol, Neutropil which claim to improve the brain metabolism
( ) b) Vitamins and tonics
( ) c) Sensory, motor stimulation and physiotherapy
( ) d) Training the child in self-help skills
( ) e) Surgery

48. Number of epileptic patients expected in 1000 population

( ) a) 1— 2
( ) b) 5—10
( ) c) 11—20
( ) d) 20 and above
( ) e) Not known

49. The following are true for genuine epileptic attacks

( ) a) Sudden unconsciousness and fall
( ) b) Self injury during attack
( ) c) Tonic-clonic-rhythmic movements of the limbs
( ) d) Tends to occur more commonly in the presence of other people
( ) e) Double incontinence during attack

50. To confirm the diagnosis of epilepsy.

( ) a) Detailed clinical history has to be collected from one or more eye witnesses.
( ) b) E.E.G. is needed
( ) c) X-ray of the skull has to be taken
( ) d) C.T. scan of brain is necessaay
( ) e) Patient is admitted and an attack is observed

51. The following epileptic patients are investigated

( ) a) Rich patients who can afford to go to a specialist centre
( ) b) First attack in patients who are above 30 years of age
( ) c) Neurological deficits on examination
( ) d) Young patients with M.R.
( ) e) Focal epilepsy

52. The following are anti-epileptic drugs :

( ) a) Diphenyl Hydration (Eptoin/Mtoin)
( ) b) Carbamazepine (Mazetol)
( ) c) Diazepam (Calmpose)
( ) d) Chlordiazepoxide (Librium)
( ) e) Chlorpromazine (Largactil)

53. Cause of epilepsy :

( ) a) Birth trauma
( ) b) Brain infection
( ) c) Hereditary
( ) d) Withdrawal of anticonvulsant drugs
( ) e) Withdrawal of alcohol

54. The following are desirable in treating epileptic patients

( ) a) Single bed-time dose
( ) b) Divided doses
( ) c) Combination of drugs
( ) d) Food restriction
( ) e) Starting with small dose, later finding out the optimum dose and maintaining it

55. Initial dose of Phenobarbitone in a 6 years child

( ) a) 15 mg
( ) b) 30 mg
( ) c) 60 mg
( ) d) 90 mg
( ) e) 120 mg

56. Maximum safe dose of phenobarbitone at PHC level :

( ) a) 150 mg/day
( ) b) 180 mg/day
( ) c) 210 mg/day
( ) d) 240 mg/day
( ) e) ruissing

57. Recognised side effects of phenytoin include

( ) a) Gum hyperplasia

( ) b) Hirsuitism
( ) c) Cerebellar ataxia
( ) d) Nystagnus
( ) e) Slurring of speech

58. An epileptic patient is advised to

( ) a) continue treatment for 5 years after the last attack
( ) b) Not to adjust the dose by himself
( ) c) Not to discontinue medication during other physical illnesses
( ) d) Not to drive vehicles/climb trees/work near fire and water
( ) e) Not to marry

59. Antiepileptic medication has to be started

( ) a) In all children aged between 6 months and 2 years who are getting febrile fits.
( ) b) In all cases of febrile fits.
( ) c) In children with repeated attacks of fever and fits (almost every month)
( ) d) In children having febrile fits with family history of epilepsy
( ) e) In children having status epilepsy with fever

60. When the patient complains of drowsiness on taking phenobarbitonr he is advised :

( ) a) To reduce the dose
( ) b) To stop the drug and to take another antiepileptic drug
( ) c) To take a drug like imipramine in addition to phenobarbitone
( ) d) Not to worry and continue the drug as before
( ) e) Remind him to take the drug at bed time only

Appendix 16

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
BANGALORE-560 029

Date .....

To

District Health Officer,
District Health & Family Welfare Office
.....

Sir,

Sub : Training of PHC Doctors and other Health Staff in Mental Health Care.

Ref :

The following Medical Officers/Health Assistants/MPWs underwent training in Mental Health Care at Rural Mental Health Centre, Sakalawara, NIMHANS, Bangalore in the month of ..... 198 .

	Name of the Doctor/MPW	PHC/PHU/Gen. Hospital
1.	.....	.....
2.	.....	.....
3.	.....	.....
4.	.....	.....
5.	.....	.....
6.	.....	.....

Please continue to depute PHC personnel regularly for this training programme and help to integrate mental health care into general health care activities. The next training programme for MPWs starts on ..... and for doctors on ..... .

Thanking you,

Yours sincerely,
(*Prof. S. M. CHANNABASAVANNA*)
Head. Dept. of Psychiatry.

Appendix 17

DEPARTMENT OF PSYCHIATRY

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
BANGALORE-29

Dear Colleague,

I have received information that you would be attending the training programme on Mental Health at MIMHANS, Bangalore from ..... to .....

I am writing to extend a warm welcome to you. The above training is of .....weeks duration. The training will be carried out at Sakalawara Rural Training Centre attached to NIMHANS, Bangalore. The centre is located 15 km away from NIMHANS. The training centre is fully furnished for your stay and boarding facilities are organised at the centre. As you know, the training is a RESIDENTIAL training.

Please contact Dr. C.R. Chandrashekar in Room No. 20 located in the administrative block of NIMHANS on arrival at the beginning of the training. The training will be starting from ..... itself. Please arrange to be at NIMHANS by 9.00 A.M. on that day.

If you need any more information kindly write to Dr. C. R. Chandrashekar, Asst. Professor of Psychiatry, NIMHANS, Bangalore 560 029.

Looking forward to meeting you when you are at NIMHANS for training.

With best wishes,

Yours sincerely,

(Prof. S. M. Channabasavanna)
Head, Dept. of Psychiatry

Appendix 18 (a)

NATIONAL MENTAL HEALTH PROGRAMME

REVIEW OF MENTAL HEALTH CARE BY PRIMARY HEALTH CARE DOCTORS

Name : Dr. .....PHC / PHU .....

Age ..... Qualification..... District .....

State..... Pin. .....

Dear Colleague,

We had the pleasure of having you with us when you participated in the training in mental health care in the month of ..... 198 . We hope that this training was useful and you have been providing services to mentally ill in your institute. We would like to understand the details of these activities and the difficulties you are facing to implement the mental health care programme. Please give your experiences so that efforts can be made to improve the programme. Thank you for your co-operation.

---

1. A. Please give a brief outline of the mental health care activities initiated at your centre following the training.

B. Mention the difficulties/problems that you encountered in implementing the programme effectively.

2. How many of the following patients have been treated by you during the last one year (or since your training in mental health) ? Mention the period .....

a) Psychoses :	i) Schizophrenia	(	)
	ii) Mania	(	)
	iii) Depression	(	)
	iv) Other psychosis	(	)
b) Neurosis		(	)
c) Mental retardation		(	)
d) Epilepsy		(	)
e) M. R. with epilepsy		(	)
		Total	

3. How often have you referred psychiatric cases to a psychiatrist ?

...../No referrals.

Please give the reasons for the referral in each case.

4. A. Kindly let us know if the following drugs are available in your centre.

Sl. No.	Drugs	Strength of Tablet	Supply is	
			Adequate	Inadequate
1.	Chlorpromazine	tab.		
2.	—do—	inj.		
3.	Diazepam	tab.		
4.	—do—	inj.		
5.	Imipramine	tab.		
6.	Phenobarbitone	tab.		
7.	Diphenyl-hydantoin (M-Toin)			
8.	Fluphenazine (Anatensol, Fludecon)	Inj.		
9.	Trihexi-phenidyl (Pacitane)	tab.		
10.	.....			
11.	.....			
12.	.....			

B. Are all of the above drugs available in the local or nearby drug shores ?
Yes/No
Which are the drugs not available in the local shores ?

5. What have been the specific instances of difficulties/doubts, if any you have faced in the following areas, while managing the psychiatric and epilepsy cases?

Diagnosis

Drug dosage

Side effects and their management

Duration of treatment

Follow up of patients

Others

6. How often have you been called to treat psychiatric emergencies ?
If yes, fill up the following :

a) Diagnosis of the cases :

b) Nature of emergency :

c) Management strategies, you adopted :

d) Referral if any :

7. What are the supports and encouragement you would like from the DHO in implementing the mental health programme ?

8. Have you started including psychiatric cases in the monthly report you send to the D.H.O ? Yes/No

9. Are you maintaining any seperate records for psychiatric cases ? Yes/No
What are the problems you are facing in maintaining the records ? What support do you require ?

10. How often have you discussed mental health care programme in your monthly meetings with the health workers ? What was their response ?

11. Does mental health care programme form part of the discussions at the District Health Office meetings ? Yes/No
Give a brief account :

12. How many of your health workers have been trained in mental health care at NIMHANS ?

13. A. Please give the approximate number of cases identified and referred to you by these trained workers during the last one year since training (mention the period .....).

a) Epilepsy .....

b) Psychosis .....

c) Mental retardation .....

B. What is your experiences with your health workers with regard to :

i) Follow up of the cases :

ii) Mental health education :

14. Have you undertaken training of other health workers in mental health care ? If yes, how and how many times ?

15. In your area, are mental health topics included in the discussion or orientation training camps for villagers ? Yes/No

Please describe :

16. In what ways are the supervisory staff (SHA, BHE etc.) of your PHC taking part in this programme ?

17. Have you initiated any mental health education activities in your institute ?

Yes/No

a) Group discussions/lectures

b) Slogan writing about mental health

c) Any other

18. How many severe mentally retarded children are getting monthly monetary help (Rs. 50/-) from the Government in your PHC area ? .....

19. How has the mental health training influenced your attitude or approach to all patients ? (Please describe in your own words) :

20. A. How often do you have to refer to the manual ?

B. What situations do you refer to the manual ?

21. Would you like to undergo a refresher training course in mental health care ?

If yes, what should be the duration of this course ?

Where should this course be organised ?

22. What are your other suggestions and views regarding the mental health care programme ?

Thanking you for your co-operation.

Signature

Date :

Appendix 18 (b)

LEVEL OF CONFIDENCE OF PHC DOCTORS IN MENTAL HEALTH CARE

Dear Doctor

After undergoing 2 weeks training in mental health care, you are managing mental health problems in your institution. Please tell us how confident you are in this work.

Mark A if you are very confident
Mark B if you are just confident
Mark C if you are less confident
Mark D if you are not at all confident
Mark NA if an item is not applicable

Case	Making diagnosis	Choosing the drug	Dosage	Counselling	When to refer to specialist
Schizophrenia					
Mania					
Depression					
Organic psychosis					
Mental retardation					
Febrile fits					
Hysteria					
Anxiety neurosis					

Thanking you,

Signature

Appendix 19

MENTAL HEALTH PROGRAMME

Monthly Report for the month of 198

Institution ..... Name of Medical Officer ..... Date .....

	Functional psychosis	Organic psychosis	Mental retardation	Neurosis	Epilepsy	Febrile fits
1. Total no. of cases in the beginning of the month.						
2. New cases registered during the month.						
3. Total						
4. Total number of cases collected drugs or came for follow up during the month.						

STOCK POSITION OF DRUGS

Drugs	Opening balance	Receipt during the month	Total	Expenditure during the month	Closing balance
1. Tab. Phenobarbitone 30 mg. 60 mg.					
2. Tab. C.P.Z. 50 mg. tab. 100 mg. tab. 50 mg. injn.					
3. Tab. Imipramine					
4. Tab. Diazepam Injec. Diazepam					
5. Tab. Pacitane					

Appendix 20

One-day Refresher cum Review meeting on Mental Health Care

Dear Health Worker,

You have been trained in mental health care at NIMHANS in the month of ..... 198 . We would like to know, how far you are able to implement the programme in your area. After knowing your achievements and problems, we shall work together to improve the programme. Please feel free to fill up this questionnaire.

Sincerely yours

NIMHANS &
Department of Health & Family Welfare
Karnataka

Your Name .....

PHC/PHU .....

Tq. .....District .....

Total years of service .....

Since how long have you been working in this centre ?.....

How much population you are covering .....

.....

1. After undergoing training, have you identified mentally ill, epileptics, and mentally retarded persons ? Yes/No

2. So far, till today, how many cases have you identified ?

   Cases of Mental illness .....

   Cases of Epilepsy .....

   Cases of Mental Retardation .....

   Total .....

3. No. of cases presently seen in your working area

	No. of cases identified	No. of cases who are on treatment	No. of cases you are following-up
Mental Illness			
Epilepsy			
Mental Retardation			

4. Is the doctor in your PHC trained in mental health care ?
Yes/No/don't know.

5. Has the doctor told you to identify and refer patients with mental ailments to the PHC ? Yes/No

6. Has a day been fixed to see mental patients in your hospital ? Yes/No

7. Which are the drugs, that are available for free distribution in your PHC ?

a) Chlorpromazine Tab. Yes/No
b) Diazepam Tab. Yes/No
c) Imipramine Tab. Yes/No
d) Pacitane Tab. Yes/No
e) Phenobarbitone Tab. Yes/No
f) Anasensol Injection Yes/No

8. Have you maintained a record book for follow-up of patients ?
Yes/No

9. Are you informing the supervisory staff about identification and follow-up of their patients ? Yes/No

10. Does discussion about mental health programme take place in PHC monthly meetings ? Yes/No

11. Till now, have you done mental health education in your area ?
Yes/No. If yes, How ? to whom ? where ?

12. Did you come across any emergency state in relation to mental disorders ? Yes/No. If Yes, what was it ? What did you do ?

13. Have you read the mental health manual ? Yes/No
If yes, under which circumstances ?

14. Are there any problems/difficulties in carrying out mental health programme in your areas ? Yes/No If yes what are they ?

15. What type of support and facilities you expect from your supervisory staff and doctors in this programme ?

16. Give your suggestions to improve this programme ?

17. Give details of the patients you are looking after.

Patients Name and what illness ?	Age	Duration of illness	Where treatment is being taken	Are you doing the follow-up

Appendix 21

Dear Health Worker,

Please fill up this questionnaire. You can refresh your knowledge. At the end, you will be told about the correct answers to these questions.

1. What is the expected number of patients in any *1000 population* ?

   Mental illness ..... Epilepsy ..... Mental Retardation .....

2. Which type of changes in the brain cause mental illness ?

3. Write 5 important features of Depressive illness

   1. ..... 2. .....

   3. ..... 4. .....

   5. .....

4. Write the names of two drugs which are commonly used to treat mental illnesses. .....

   .....

5. Write 4 common side effects of these drugs

   1. ..... 2. .....

   3. ..... 4. .....

6. Then what do you do ?

_____

_____

7. How long medicines have to be given in mental illness ?.....

8. Write 3 causes for illness not subsiding inspite of giving medicines.

   1. _____

_____

2. _____

3. _____

9. What first aid you would give to a patient who is having a fit ?

_____

_____

_____

10. What is the name of the drug given to treat epilepsy ?

_____

11. Inspite of taking this drug, if fits are not controlled, what are the reasons ?

12. What are its side effects .....

13. Inspite of taking this drug, if fits are not controlled, what are the reasons ?

_____

_____

_____

14. How long one should take phenobarbitone for epilepsy to get cured ?

_____

15. What do you do of a child who develops epilepsy ?

_____

_____

16. What changes do you see in the brain of an epileptic patient ?

17. What happens to the brain of a mentally retarded child ?

18. Write 5 preventable causes of Mental Retardation.

19. Is there a drug which can cure Mental Retardation ? If yes. What it is ?

20. Write 3 important advices to be given to the parents of mentally retarded children ?

21. Write emergencies which are seen in relation to all these disorders ?

_____

_____

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